REPORT ON THE USE OF SECLUSION AND RESTRAINT AT WESTERN STATE HOSPITAL

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The Department for Rights
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PURPOSE OF STUDY AND REPORT

The Department for Rights of Virginians with Disabilities (DRVD), the Protection and Advocacy System for the Commonwealth of Virginia, has studied and plans to report on the use of seclusion and restraint methods at psychiatric hospitals licensed and operated by the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS). This initial report is focused on the state hospital located in Staunton, Virginia: Western State Hospital (WSH).

Through its Protection and Advocacy for Individuals with Mental Illness (PAIMI) Program, DRVD monitors human rights conditions at DMHMRSAS facilities and advocates for the rights of patients who have been subjected to seclusion and restraint.

With the goal of eliminating entirely the inappropriate use of seclusion and restraint methods and of reducing the overall use of seclusion and restraint, DRVD has undertaken a systemic review of the use of those methods at DMHMRSAS facilities. This Report presents the results of DRVD's review of seclusion and restraint usage at Western State Hospital (WSH).

By and through this Report, DRVD seeks to work cooperatively with WSH to reduce its use of seclusion and restraint methods and to ensure that, when such methods are utilized, that there are reasonable and adequate safeguards in place to protect the health and welfare of both patients and staff.

The dangers of seclusion and restraint methods are well documented. A 1999 Report by the United States General Accounting Office identified seclusion and restraint as "a significant risk" to persons with disabilities and, citing a series of articles in the Hartford Courant, identified 142 deaths in a ten year period related to seclusion and restraint methods. GAO made clear that, in order to protect the health, welfare, and civil rights of persons with disabilities, facilities must reduce their usage of seclusion and restraint methods.[1]

With this goal in mind, DRVD reviewed WSH's principles and policies regarding the use of seclusion and restraint methods. Those policies are set forth in WSH's Hospital Instruction Number 4015 (hereinafter referred to as "WSH's Policy" or "its Policy"), entitled "Emergency Use of Seclusion and Restraint."[2]

The stated purpose of WSH's Policy is:

> [T]o establish policies and procedures for the use of emergency seclusion and restraint with adult patients and to assure that all hospital policies and procedures
>
> - are consistent with applicable rules and regulations and DMHMRSAS Departmental Instruction;
> - are designed to minimize the use of restrictive procedures; and
>
> afford maximum protection of patients and staff.

This Report interprets data collected and analyzed by DRVD staff regarding patterns

[1] 1 September, 1999 Report of the United States General Accounting Office, "Mental Health: Improper Restraint or Seclusion Use Places People at Risk."

and practices in WSH's use of seclusion and restraint and presents findings concerning WSH's adherence to its Policy. Finally, the Report offers recommendations of ways WSH can decrease its use of seclusion and restraint methods. The recommendations are based upon a Pennsylvania Department of Public Welfare program which dramatically reduced the usage of seclusion and restraint in that state's psychiatric hospitals.

[2] A copy of WSH's Policy is attached hereto as Appendix A

WHAT CONSTITUTES SECLUSION AND RESTRAINT?

WSH's Policy defines "seclusion" as

> The involuntary placement of a patient in a room with the door blocked, secured, or locked in a manner which prevents the individual from leaving.

WSH's policy defines "restraint" as

> [T]he use of approved physical interventions or mechanical restraint devices that involuntarily restrict the freedom of movement or voluntary functioning of a limb or a portion of a person's body. Any device that the patient is unable to remove is considered a restraint, even if it is used for protective purposes.

Throughout this Report, the term "seclusion and restraint" will be used to describe any measure which meets the definition of "seclusion and restraint" as set forth in WSH's policy manual. [3]

[3] It should be noted that this Report does not seek to interpret WSH's use of seclusion and restraint in the light of the standards set forth by the Children's Health Act of 2000. The incidents of seclusion and restraint reviewed by DRVD took place prior to the enactment of the Act; thus, it would be unfair to hold WSH, *ex post facto* , to them. However, DRVD will undertake a follow-up study of the use of seclusion and restraint methods at WSH to ascertain whether WSH complies with the requirements of the Act and what, if any, steps WSH has taken to decrease it usage of seclusion and restraint subsequent to this Report.

SUMMARY OF FINDINGS

While WSH has decreased its use of seclusion and restraint over the past three years, it has not consistently followed its Policy. Most disturbingly, WSH has often failed to adhere to its Policy of only using seclusion and restraint "following attempts to intervene in a less restrictive, less invasive manner."

WSH also failed to adhere to its Policy regarding the types of seclusion and restraint to be used, resulting in many instances in which more restrictive methods of seclusion and restraint were used than warranted.

WSH instigated seclusion and restraint methods in response to non-emergency situations.

Patients were often not informed of the reason(s) they were being secluded or restrained or the criteria for release from seclusion and restraint, in violation of WSH's Policy, thus decreasing or defeating any value of the method except as a punishment.

SUMMARY OF RECOMMENDATIONS

Seclusion and restraint methods must only be used as interventions of last resort. These methods must only be used to protect patients from injuring themselves or others. Complete and accurate documentation and records must be kept to show that measures less restrictive than seclusion and restraint were tried before initiating seclusion and restraint measures.

- When seclusion and restraint methods are necessary, the least restrictive method must be used. Complete and accurate documentation and records must be kept to show that less restrictive methods of seclusion and restraint were tried before moving to those requiring more restriction.
- Seclusion and restraint methods should not be used as a response to loud, inflammatory, or even threatening verbalizations.

  WSH must explain to patients the reason they are being subjected to seclusion and restraint methods and the criteria for release therefrom.
- WSH staff must follow WSH's policy as written, including the documentation requirements. Hospital administration must enforce this requirement.

METHODOLOGY OF STUDY

Prior to commencing this study, DRVD staff met with WSH Director M.D. to explain the reason for this study, how DRVD would carry it out and what DRVD hoped to accomplish.

First, in order to study WSH's aggregate use of seclusion and restraint methods over the prior three fiscal years, DRVD collected and analyzed data from DMHMRSAS, setting forth, for each month, the percentage of WSH patients who had been subjected to seclusion and restraint and the total number of hours in which WSH patients had been secluded or restrained.

Then, in order to conduct an in-depth analysis of each case of seclusion and restraint from January-March, 2000, DRVD made several visits to and inspections of WSH. Through interviews with WSH staff, who were very cooperative, DRVD identified those patients who had been subjected to seclusion and restraint during that period DRVD staff then conducted in-depth interviews with those identified patients still residing at WSH.[4] The interviews included questions concerning the behaviors which led to the seclusion and restraint, the process of being placed in seclusion and restraint and their actions and the

[4] Each patient signed a release of information to allow DRVD staff to review their records and to gather information about their cases. Incidents regarding patients who had been discharged from WSH prior to this study are not included in this Report.

actions of WSH staff while they were secluded and/or restrained.

After the interviews, DRVD staff carefully reviewed the charts of each patient, studying the records and information concerning each incident of seclusion and restraint identified by WSH staff and patients. DRVD staff then entered the relevant data onto its Seclusion/Restraint Usage Review Form[5] and analyzed each case to determine whether, in each instance and in the aggregate, WSH complied with its Policy. This Report represents a summary and analysis of that data.

[5] A blank copy of the DRVD Seclusion/Restraint Usage Review Form as well as a representative sample of the Forms used in this study, with patient names/identifying data redacted, are attached hereto as Appendix B.

WSH POLICY REGARDING THE USAGE OF SECLUSION AND RESTRAINT

This section will set forth relevant portions of WSH's Policy regarding the use of seclusion and restraint methods.[6]

I When seclusion and restraint measures may be utilized:

> Restraint or seclusion are [*sic.*] interventions of last resort following attempts to intervene in a less restrictive, less invasive manner, with the goal of ensuring the safety and protection of the patient and others at risk.
> (WSH Policy, page 3)
>
> A patient may be placed in seclusion or restraint only:
>
> - when necessary to prevent the patient from physically harming self or others;
> - after less restrictive alternative interventions have been unsuccessful; and
> - when authorized by a physician.
>
> (WSH Policy, page 4) (emphasis added)

II. Reasons for which seclusion and restraint are NOT to be used:

> While protection of other patients from physical harm is a valid indication for seclusion or restraint, social behavior that irritates or annoys others is **not** an indication for use.
> (WSH Policy, page 4) (emphasis added)

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[6] It should be noted that WSH's Policy generally comported with then applicable regulations and standards published by the Health Care Financing Administration (HCFA) and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).

III. Procedures before initiating seclusion and restraint

Before initiating the use of emergency restraint or seclusion, staff will attempt to manage the patient's behavior using interventions that are less restrictive than seclusion or restraints.

Less intrusive interventions include, but are not limited to verbal and behavioral interventions, recreations intervention, redirection, time-out (i.e. placing a patient in a room with an unlocked door), and environmental modifications.
(WSH Policy , page 5) (emphasis added)

IV. Use of least restrictive method of restraint

Once a determination has been made that restraint is necessary, the least restrictive restraint device (e.g. ambulatory restraints) that will effectively address the patient's behavior must be selected.
(WSH Policy, page 5) (emphasis added)

V. Review with and observation of resident in seclusion and restraint:

After the patient has been placed in mechanical restraints or seclusion, a designated staff person will discuss with the patient

- the specific behaviors that necessitated restraint or seclusion
- how the patients behavior continues to meet the criteria
- the behaviors that must be demonstrated for release or for a reduction in mechanical restraint
- the patient's suggestions for how staff can assist him to gain release from mechanical restraint or seclusion.

Staff must document in the clinical record

- their attempts to communicate this information to the patient
- the patient's response to the intervention; and
- any difficulties the patient has in understanding the information being communicated by the staff person.

(WSH's Policy, page 9) (emphasis added)

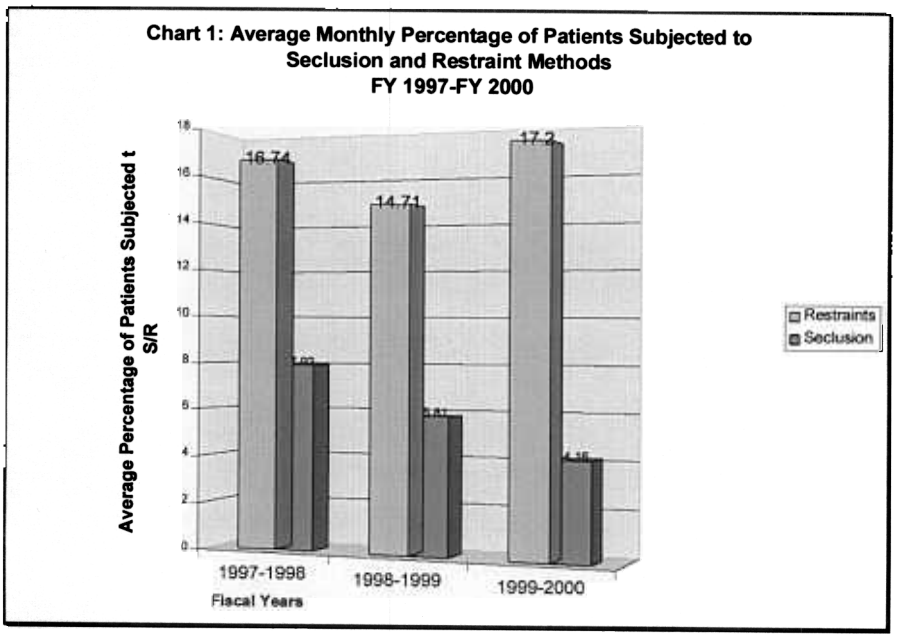
FINDINGS

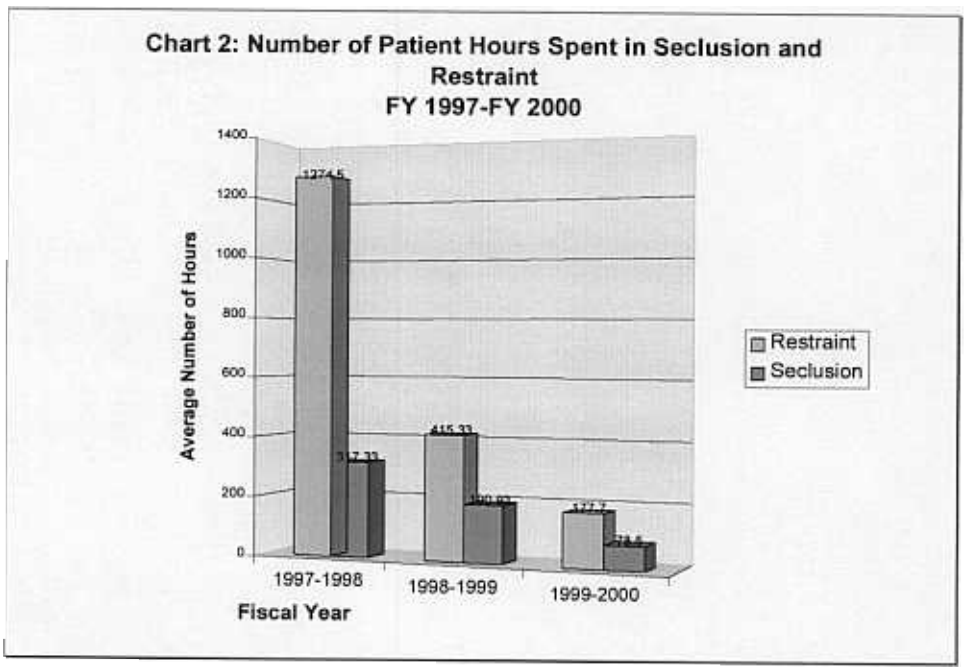
This section is divided into subsections addressing (1) WSH's aggregate use of seclusion and restraint from FY 1997-98 to FY 1999-2000 and (2) WSH's use of seclusion and restraint during the period from January-March, 2000.

I. Aggregate use of seclusion and restraint from FY 1997-98 to FY 1999-2000

DRVD staff requested and reviewed data from the Commissioner of DMHMRSAS setting forth WSH's use of seclusion and restraint over the prior three fiscal years. As is more fully set forth below, WSH's use of seclusion and restraint has, in general, decreased over that period. See Charts 1and 2.[7]

[7] A spreadsheet setting forth the monthly use of seclusion and restraint from FY 1997 through FY 2000 is attached as Appendix C





During fiscal year 1997-1998, the average percentage of patients restrained per month

was 16.74, with a high of 20 in March of 1998 and a low of 12.3 in December, 1997. average number of patient hours in restraint per month was 1,274.5, with a high of 1,936 hours in August of 1997 and a low of 756 hours in July, 1997. The average percentage of patients secluded per month was 7.92, with a high of 10.5 in July of 1997 and a low of 6.4 in June, 1998. The average number of patient hours in seclusion per month was 317.33, with a high of 652 hours in June of 1998 and a low of 121 hours in January, 1998.

During fiscal year 1998-1999, the usage of both seclusion and restraint decreased. The average percentage of patients restrained per month during the 1998-1999 fiscal year was 14.71 with high of 16.8 in July of 1998 and a low of 10.8 patients in April, 1999. average number of patient hours in restraint per month was 415.33, with a high of 846 hours in December of 1998 and a low of 87 hours in April, 1999. The average percentage of patients secluded per month was 5.81, with a high of 7.6 in July of 1998 and a low 3.1 in February, 1999. The average number of patient hours in seclusion per month was 190.92, with a high of 445 hours in July of 1998 and a low of 61 hours in November, 1998.

During fiscal year 1999-2000, the average percentage of patients restrained increased to 17.2 per month, with a high of 22 in November of 1999 and a low of 13.2 in July, 1999. However, the average number of patient hours in restraint per month decreased to an average of 177.7, with a high of 249 hours in November, 1999 and a low of 58 hours in January, 2000. The average percentage of patients secluded per month was 4.16, with a high of 7.8 in September of 1999 and a low of 2.5 in January, 2000. The average number of patient

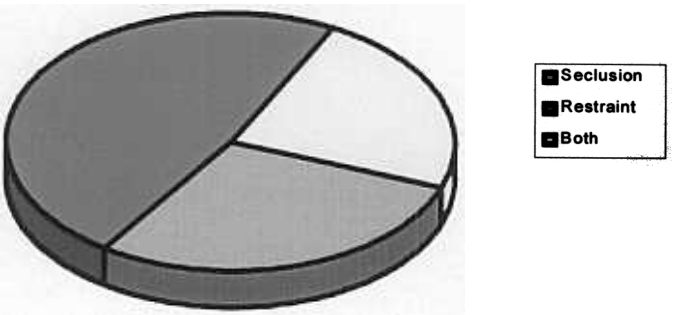
hours in seclusion per month was 78.5, with a high of 150 hours in September of 1999 and a low of 17 hours in January, 2000.

II. Use of seclusion and restraint from January-March, 2000

DRVD closely analyzed a total of 35 incidents of seclusion and restraint occurring from January to March, 2000.[8] This total included 10 incidents, or 29%, involving the use of seclusion alone, 17 incidents, or 48%, involving the use of restraint alone, and 8 incidents, or 23%, utilizing both seclusion and restraint either simultaneously or in tandem. See Chart 3 .

[8] It should be noted that 20 of these incidents involved one patient. This fact does not effect the findings or recommendations made herein. This Report focuses on WSH's actions when staff initiates seclusion and restraint methods, not on the identity or number of patients secluded and restrained. As such, the facts and circumstances surrounding the cases studied, and not the number or identity of the patients secluded or restrained, are the relevant issues herein.

Chart 3: Proportional Use of Seclusion, Restraint & the Simultaneous or Tandem Use of Both in Cases Studied



DRVD's study of the incidents revealed several areas of concern. These are addressed in the next section.

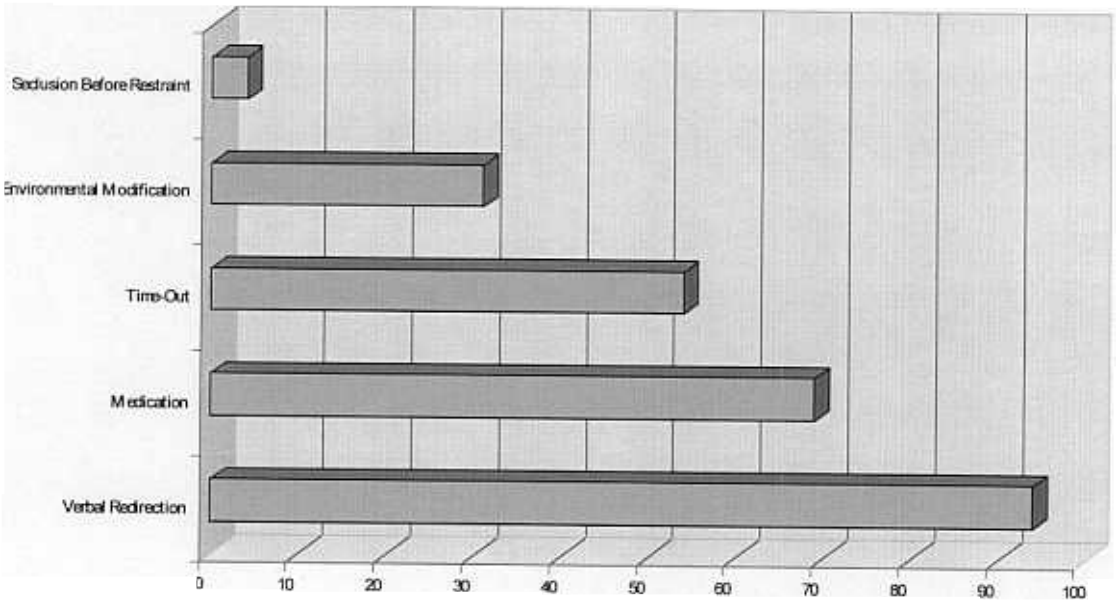
AREAS OF CONCERN

I. Failure to use less restrictive interventions before using seclusion or restraint

WSH staff often failed to use less restrictive interventions before subjecting patients to seclusion and restraint methods. Such failures were in clear violation of WSH's Policy, which states that seclusion and restraint are "interventions of last resort following attempts to intervene in a less restrictive, less invasive manner." (WSH Policy, page 1).

Despite WSH's Policy containing a list of less restrictive interventions to be used before seclusion and restraint methods (WSH Policy, page 5), such methods were often used before other less restrictive interventions were tried. While verbal redirection, used in 94% of the studied incidents, and the use of medication, used in 69% of studied incidents, were commonly employed, other less restrictive interventions were used far less frequently. The intervention of time-out was utilized in only 54% of cases and the interventions of a change of environment or environmental modification were used in only 31% of cases. Finally, in the 25 incidents where restraints were used, seclusion was tried as an intervention before moving to restraint in only one case. See Chart 4.

Chart 4: Less Restrictive Measures



WSH's use of seclusion and restraint methods prior to attempting less restrictive interventions also violates generally accepted principles that such use presents a health hazard to patients. In 1998, a series of articles published in the Hartford Courant found that between 50 and 150 deaths occurred each year which were attributable to the use of seclusion and restraint methods.[9] The articles concluded that a reduction in the use of seclusion and restraint methods requires "a. . . philosophical commitment – a commitment to use force only as a last resort. . "[10]

In February of 1999, the American Hospital Association and National Association of Psychiatric Health Systems, "expressing concern over recent Reports of death and injury

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[9] A Nationwide Pattern of Death, by Eric M. Weiss, published in the Hartford Courant, 11 October, 1998.

[10] Why they Die: Little Training, Few Standards, Poor Staffing Put Lives at Risk, by Kathleen Megan and Dwight F. Blint, published in the Hartford Courant, 12 October, 1998.

from the use of restraint and seclusion interventions with psychiatric patients" issued their Guiding Principles on Restraint and Seclusion. The principles:

> identify seclusion and restraint as emergency interventions which aim to protect patients in danger of harming themselves or others. When used properly, they can be life-saving and injury sparing interventions. However, both organizations advocate using seclusion and restraint as infrequently as possible and only when less restrictive methods are considered but not feasible.[11]

In September, 1999, the United States General Accounting Office issued a Report entitled Improper Restraint or Seclusion Use Places People at Risk. The Report recommended that seclusion and restraint be used in emergency situations only when:

> necessary to ensure the individual's or others' physical safety and after less restrictive interventions have been ineffective to protect the individual or others from harm.[12]

Hence, WSH's tendency to use seclusion and restraint methods before attempting other, less intrusive, interventions is particularly troubling. This issue, beyond any question, presents the greatest area of concern found by DRVD in this study and one which must be rectified if the safety of WSH patients is to be ensured.

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[11] 26 February, 1999 Joint Press Release by the American Hospital Association and National Association of Psychiatric Hospital Health Systems upon the release of their Guiding Principals on Restraint and Seclusion for Behavioral Health Services. (emphasis added).

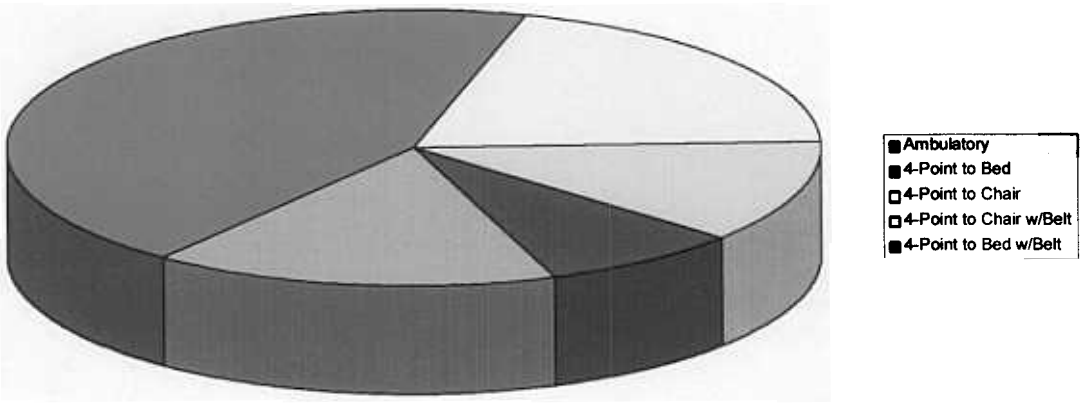
[12] September, 1999 Report of the United States General Accounting Office, "Mental Health: Improper Restraint or Seclusion Use Places People at Risk.", p. 23-24 (emphasis added).

II. Failure to use less restrictive methods when patient is in seclusion and restraint.

Another area of great concern is WSH's consistent failure to use less restrictive methods when a resident is subjected to seclusion and restraint. WSH's Policy clearly requires that, when seclusion and restraint methods are used, WSH staff must use "the least restrictive restraint device." (WSH Policy, page 5). This requirement notwithstanding, DRVD's investigation found that ambulatory restraints, the least restrictive method of restraint, were used in only 16% of the cases studied. Instead, far more restrictive methods were consistently used: 4-point to bed restraints, the second most restrictive method of restraint, was used in 44% of restraint cases, 4-point to chair restraints were used in 20% of restraint cases, 4-point to chair with belt restraints were used in 12% of cases and 4-point to bed with belt restraints were used in 8%. See Chart 5.

WSH's use of more restrictive methods of restraint is particularly troubling in light of the data Reported by the Hartford Courant. Of the deaths Reported in the Courant, almost 20% were linked to the patient being held in 4-point or greater restraints. Thus, WSH's failure to use less restrictive restraint, in violation of its own policy, clearly puts the health of its patients at risk.

Chart 5: Types of Restraint



III. Use of seclusion and restraint when not warranted.

Another troubling trend was WSH's use of seclusion and restraint in non-emergency instances. WSH's Policy clearly states that the only time seclusion and restraint methods may be used is "when necessary to prevent the patient from physically harming self or others." (WSH Policy, page four). However, in 23% of the cases studied, the behavior precipitating the use of seclusion and restraint did not rise to this level.

In the majority of these cases, WSH staff initiated seclusion and restraint in response to patients' verbalizations such as threats, anger, and cursing One particularly disturbing incident occurred when a patient verbally abused a physician, was ordered into restraints and then calmly walked into the seclusion room and quietly allowed WSH staff to restrain him. Such behavior is hardly indicative of the threat of "serious harm" required to instigate

seclusion and restraint methods. In other cases, there was no documentation in the patients' files to indicate that they represented a threat to their own safety or the safety of others before being placed in seclusion and restraint.

Besides violating its own Policy, WSH's use of seclusion and restraint methods in non-emergency situations runs afoul of the Recommendations stated in the General Accounting Office Report, which stressed that patients should have the right to "be free from any physical or chemical restraints or seclusion imposed for the purposes of coercion, discipline or staff convenience. . . ."[13] Such use of seclusion and restraint methods robs both the patients and the staff of their dignity and decreases any probative value of the method.

IV. Failure to inform patients of the behavior precipitating the use of seclusion and restraint and the criteria for release therefrom.

Another alarming trend was WSH's failure to inform patients of the reasons for their being placed in seclusion and restraint and the criteria for being released therefrom. WSH Policy clearly requires that patients be given this information (WSH Policy, page 9). Nevertheless, based upon WSH's documentation, in 86% of the cases studied, the reason for the seclusion and restraint was not communicated to the patient and in 37% of cases, the criteria for release was not communicated.

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[13] September, 1999 Report of the United States General Accounting Office, "Mental Health: Improper Restraint or Seclusion Use Places People at Risk.", p. 23.

The failure to provide this information robs the use of seclusion and restraint methods of any efficacy or value. If patients are not informed of the behavior which led to the use of seclusion and restraint and the behavior which will gain their release, they will not be able to understand the reasons for the intervention and how to avoid it in the future. In short, the seclusion and restraint methods will become solely punishment tools. Such use runs contrary to WSH Policy as well as the General Accounting Office's Recommendations, giving patients the right to be free from seclusion and restraint used for the purposes of coercion or punishment.

RECOMMENDATIONS

I. WSH must attempt less restrictive interventions before resorting to the use of seclusion and restraint methods

WSH must take aggressive steps to ensure that less restrictive interventions are attempted before resorting to seclusion and restraint methods. Staff must be rigorously trained to recognize that seclusion and restraint are interventions of last resort, to be used only when other methods have failed or are not possible. Anything less contributes to the unwarranted use of seclusion and restraint by creating an atmosphere where those restraint methods are used for punishment or the convenience of staff, rather than the health and safety of the patient.

Such steps, when vigorously taken and consistently enforced, have been successful in reducing the usage of seclusion and restraint in other states. The Pennsylvania Office of Mental Health and Substance Abuse Services was recently named one of ten national winners in Harvard University's Innovations in Government Program for its groundbreaking program which dramatically reduced the usage of seclusion and restraint methods (hereinafter referred to as "the Pennsylvania Program"). Through this program, the use of seclusion and restraint in Pennsylvania's nine psychiatric hospitals decreased 74 percent and hours of use decreased 96 percent. The keystone of this program is Pennsylvania's

commitment that "seclusion and restraint techniques reflect treatment failure."[14]. In furtherance of this commitment, Pennsylvania developed a policy limiting the use of those methods to only those emergency situations "when less restrictive treatment options/interventions. . have been formulated, attempted and are documented to have failed." (Pennsylvania Policy, page 8) (emphasis added).

In particular, WSH must emulate the Pennsylvania project in requiring that its staff document each intervention attempted prior to the instigation of seclusion and restraint methods in order to demonstrate a progression of interventions, from non-physical to physical techniques which require less restriction to those which require more restriction. It is only through such documentation that WSH can monitor and police its use of seclusion and restraint and be sure that the use of those methods was a last, rather than a first, resort.

II. When WSH utilizes seclusion and restraint methods, it must use the least restrictive method.

WSH must make a firm commitment to use, in those rare instances where seclusion and restraint methods are warranted, only the amount of seclusion or restraint necessary to address the situation. Given the high risk of patient injury or death associated with the use

[14] "Pennsylvania's Seclusion and Restraint Reduction Initiative, Overview," page 1 (hereinafter referred to as "Pennsylvania project Overview"). Published by Pennsylvania Department of Public Welfare. A copy of this document and the Pennsylvania Program's Policy, entitled "Use of Restraints, Seclusion, and Exclusion in State Mental Hospitals" (hereinafter referred to as "Pennsylvania Policy"), is attached hereto as Appendix D.

of more restrictive methods, WSH should take steps to ensure that, when seclusion and restraint methods are used, they are used solely as treatment tools, rather than as punishment or for the convenience of staff.

WSH must comprehensively train its staff in the proper use of seclusion and restraint methods. Only in this way can WSH be sure that its staff understands that, while greater restraints may temporarily quiet a "problem" patient, such methods are done at the cost of patient health and welfare. Concurrent with such training, WSH should require detailed documentation of each instance of seclusion and restraint in order to establish that the methods used progressed from least to most restrictive. It is only through this documentation that WSH can adequately judge whether its staff is complying with its Policy.

III. WSH must only use seclusion and restraint methods when they are clearly warranted.

WSH staff must not use seclusion and restraint methods when they are not warranted. DRVD's study uncovered a disturbing trend of WSH staff using seclusion and restraint in response to verbal abuse or aggressiveness. Such actions are in violation of WSH's Policy, which states that seclusion and restraint are to be used only to protect patients and others from physical harm. A patient's use of loud, inflammatory or even abusive language does not present such a danger.

The Pennsylvania program makes clear that seclusion and restraint methods are only

to be used "as a last resort to situations involving imminent serious harm." Pennsylvania hospital staff are comprehensively trained in techniques designed to "pay close attention to the factors that cause or escalate aggressive and self-injurious behavior." (Pennsylvania project Overiew, page 1). As a result, "seclusion and restraint are no longer considered the acceptable response to aggressive or self-injurious patient behavior." (Pennsylvania project Overview, page 2).

IV. WSH must clearly explain to patients both the reason(s) why they have been placed in seclusion and restraint and the criteria for release therefrom.

WSH must consistently explain to patients the reason(s) they were subjected to seclusion and restraint methods and the criteria for release therefrom. If seclusion and restraint techniques are to have any therapeutic effect, patients must understand the behavior that led to it, so that they may regulate or avoid such behaviors in the future, as well as the behavior that is necessary to gain release, so that they may endeavor to exhibit it. Having this information gives patients power in a situation where they may otherwise feel powerless.

It is also vitally important that WSH staff meet with a patient as soon after release from seclusion and restraint as possible. By doing so, WSH can gain insight into the patient's experience while in seclusion and restraint and learn techniques to avoid having to use such methods in the future.

The Pennsylvania program requires debriefing of both patients and staff after each

instance of seclusion and restraint and the revision of treatment plans based upon the results of the meeting. (Pennsylvania Policy, page 5 [seclusion methods], page 9 [restraint methods]). These requirements have "enhanced physician involvement and accountability [and] increased patient safety." (Pennsylvania project Overview, page 2).

V. WSH staff must follow WSH's policy as written, including the documentation requirements. Hospital administration must enforce this requirement.

Critical to the success of any Policy regarding the use of seclusion and restraint is WSH's level of commitment to enforcing that Policy, including the provision of adequate training to its staff and the rigorous documentation and correction of any failures to follow the Policy. While such a recommendation may seem self-evident, it should be noted that WSH's Policy clearly called for at least some permutation of each of the actions recommended herein. Unfortunately, the most consistent problems noted by DRVD stemmed from WSH's failure to enforce its Policy. Such failures wholly defeat the purposes of the Policy: a Policy stating that seclusion and restraint methods are "interventions of last resort following attempts to intervene in a less restrictive, less invasive manner," is rendered meaningless if not enforced. Unless WSH does so, its staff will continue to use seclusion and restraint methods when not warranted, and its patients will continue to be put at risk.

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APPENDIX A: WESTERN STATE HOSPITAL INSTRUCTION NUMBER 4015, "EMERGENCY USE OF SECLUSION AND RESTRAINT"

WESTERN STATE HOSPITAL
Staunton, Virginia

Hospital Instruction Number 4015

January 4, 2000

Subject: **Emergency Use of Seclusion and Restraint**

Background: Patients in DMHMRSAS hospitals are treated with the least restrictive intervention/interaction appropriate to their needs. DMHMRSAS facilities exercise leadership to create a physical, social and cultural environment that reduces the needs for and limits the use of seclusion and restraint as much as possible.

Purpose: The purpose of this Instruction is to establish policies and procedures for the use of emergency seclusion and restraint with adult patients and to assure that all hospital policies and procedures:

- are consistent with applicable rules and regulations and the DMHMRSAS Departmental Instruction;
- are designed to minimize the use of restrictive procedures; and
- afford maximum protection of patients and staff.

Applicability: **All Direct Care Staff Trained in Approved Techniques/Procedures, i.e. MANDT**

Definitions: The following definitions will apply to this Hospital Instruction:

Constant Observation: Constant observation is the continuous visualization of the patient by a staff member who:

- has no other assignment, and
- is not performing any other duties or activities.

Constant observation includes those times when the patient is in the bathroom, including the toilet and shower areas.

All restrained patients will be on constant observation or direct or (1:1) based on clinical indications.
All secluded patients will be within eyesight of the staff.

Direct Observation

- the patient is in direct sight at all times with no physical barriers between the patient and the staff member
- staff member has no other assignment
- staff member is not performing any other duties or activities

1:1 Observation:

- the staff member is within arms reach of the patient
- the staff member has no other assignment
- the staff member is not performing any other duties or activities

Emergency:

An emergency is an unplanned situation in which it is immediately necessary to restrain or seclude a patient:

- to prevent imminent probable death or substantial bodily harm to the patient because he is overtly or continually threatening or attempting to commit bodily harm; OR
- to prevent imminent physical harm to others because of threats, attempts to harm others, or other acts the patient overtly makes or commits; and
- when preventive de-escalative or verbal techniques have proven ineffective at diffusing the potential for injury or destruction.

Medical Restraint:

Medical restraint refers to the use of a mechanical device for a medical, diagnostic, or surgical purpose to prevent the patient from:

- removing medically indicated devices such as dressings, catheters, intravenous, nasogastric or gastric tubes
- interrupting acute medical or post-surgical treatment
- experiencing self-injury secondary to a medical condition, i.e. Huntington's Chorea or other neurological impairment

Mechanical devices used for the purpose of medical restraint include, but are not limited to, mittens, wrist or ankle limb holders, posey vests.

Protective device:

Protective device means a mechanical device used for a specific protective or supportive purpose to:

- maintain body position or balance
- prevent injury through a passive barrier such as a jumpsuit or helmet, or
- assist the movement of an individual whose mobility is impaired by a physical disorder.

Mechanical devices typically used for protective purposes include Geri-chairs, side rails and limb holders.

Restraint:

Restraint means the use of approved physical interventions or mechanical restraint devices that involuntarily restrict the freedom of movement or voluntary functioning of a limb or a portion of a person's body. Any device that the patient is unable to remove is considered a restraint, even if it is used for protective purposes.

Physical interventions entail the use of various approved techniques to prevent a patient from freely moving his limbs or body to engage in a behavior that places him or /others at risk of physical harm until such time as he is either calm, secluded or placed in mechanical restraint.

Physical interventions must comply with the Department-approved behavioral interaction and crisis management techniques and follow the hierarchy of least restrictiveness. See Departmental Instruction 104 (TX)99 Behavior Interaction and Management Techniques Training (currently MANDT training.)

Mechanical restraint refers to the use of approved restraint devices that:

- are designed to prevent or limit the use of a limb or a portion of the person's body, and
- the individual is unable to remove without assistance.

Transport Restraint refers to the use of approved restraint devices that:

- are designed to prevent elopement or assaultive behavior
- are time limited to the duration of the transport
- may be used on or off grounds.

Patients will only be restrained in accordance with Hospital Restraint Formulary.

Medications are not an approved form of restraint and will not be used to restrict a person's voluntary movements.

Seclusion: The involuntary placement of a patient in a room with the door blocked, secured, or locked in a manner that prevents the individual from leaving.

Responsible Authority

Facilities: The facility director will ensure compliance with the Hospital Instruction. To the extent any inconsistency exists between a Departmental and Hospital Instruction or policy the more restrictive will control.

Specific Guidance

Statement of Principles:

1. Restraint or seclusion are interventions of last resort following attempts to intervene in a less restrictive, less invasive manner, with the goal of ensuring the safety and protection of the patient and others at risk.
2. Medications are not an approved form of restraint and will not be used for the purpose of immobilizing an individual, inducing a state of sleep or reducing the ability to move freely.
3. The decision to use seclusion or restraint must take into consideration any specific, unique characteristics of the individual patient.
4. Protective, medical and supportive devices will not be used as substitutes for seclusion and restraint.
5. Seclusion or restraint will be implemented in a manner that protects and preserves the rights, dignity and well-being of the patient.
6. Seclusion or restraint will not be used as punishment, as a convenience for staff, as a substitute for treatment or habilitation, or in a manner that causes undue physical discomfort or harm to the patient.
7. PRN (as needed) orders for seclusion or restraint are prohibited.
8. The least restrictive means of mechanical restraint, as determined for the individual by a physician with knowledge of the patient's preference, will be used to address the patient's behavior. Preference should be given to the use of ambulatory restraints over bed/chair restraints, when clinically indicated.

9. The patient and the family will be educated on the need for the use of emergency seclusion and restraint as soon as possible following admission and consulted about what interventions have been most effective in addressing those behaviors of the patient that endanger the safety of self or others.

All patient and family education will be documented in the patient's record.

Criteria for emergency Seclusion and Restraint Use:

O A patient may be placed in seclusion or restrained only:
- when necessary to prevent the patient from physically harming self or others;
- after less restrictive alternative interventions have been unsuccessful, and
- when authorized by a physician.

O While protection of other patients from physical harm is a valid indication for seclusion or restraint, social behavior that irritates or annoys others is not an indication for use.

Contraindications:

Seclusion and restraints may be dangerous and contraindicated for use because of the patient's psychiatric or medical condition. Contraindications may include, but are not limited to the following conditions:
- obesity
- unstable medical status resulting from infection, cardiac or respiratory illness, disorders of thermo-regulation of metabolic illness
- circulatory obstruction or history of aspirations
- complications of immobility (such as pressure ulcers or incontinence)
- a history of physical or sexual abuse
- confusion and disorientation, which may be exacerbated by conditions of sensory deprivation
- seizure disorders
- history of trauma; and
- untoward psychological effects including feeling of depression, humilitation and anger.

O The clinical benefits for the use of seclusion or mechanical restraint must outweigh the known risks, and the documented by the physician in the clinical record.

O Seclusion is contraindicated for patient's with serious and uncontrollable self-abuse and self-mutilation.

O Suicidal patients should never be secluded without constant observation.

Patient records must be flagged to indicate S/R contraindications.

Training:

All identified facility staff will receive specialized training in the Department approved behavioral interaction and crisis management techniques. See Departmental Instruction 104(TX)99 Behavior Interaction and Management Techniques Training (currently MANDT training).

Procedures

Hospital:

Policies and procedures for the use of seclusion and restraint must be consistent with this Instruction. To the extent any inconsistency exists between this Instruction and hospital policies and procedures, the more restrictive policy will control. These policies and procedures will be reviewed at least annually.

Hospital procedures will address the proper management of patients in restraint or seclusion during evacuation of the hospital due to drills or actual disasters.

Medical policies:

Each patient will receive a medical assessment upon admission and whenever the medical condition of the patient warrants or the condition of the patient changes. This medical assessment must consider risk factors that would contraindicate the use of restraint or seclusion.

Seclusion rooms:

The hospital staff will ensure that the seclusion room is free of any potentially dangerous item or structural defects and is maintained in compliance with Departmental Instruction 604(EM)94 Time Out and Seclusion Rooms.

Least restrictive interventions:

Before initiating the use of emergency restraint or seclusion, staff will attempt to to manage the patient's behavior using interventions that are less restrictive than seclusion or restraints:

Less intrusive interventions include, but are not limited to verbal and behavioral interventions, recreational intervention, redirection, time-out (i.e. placing a patient in a room with an unlocked door), and environmental modifications. Once a determination has been made that restraint is necessary, the least restrictive restraint device (e.g., ambulatory restraints) that will effectively address the patient's behavior must be selected.

Physician's orders:

Seclusion or restraint will be implemented only pursuant to the written order of a licensed physician.

Assessment and Determination: Before writing an order to authorize the use of seclusion or restraint, a physician must personally:

- review the precipitating circumstances
- identify the least restrictive restraint device to address the patient's behavior
- assess the patient's physical and mental condition, review the most recent medical assessment, and identify any contraindications for use of the procedure; and
- determine that use of seclusion or restraint is required for this patient.

Documentation of Assessment: The physician will document in the clinical record:

- the results of his assessment and
- that he has considered whether a contraindication exists and none does, OR he has considered the specific contraindication(s) and the benefits of seclusion or restraint outweigh the known risks
- rationale for selection of type of restraint or seclusion.

Written Order: The physician's written order for seclusion or restraint must include the following:

- type of restraint selected (refer to WSH Restraint Formulary)
- duration of the order may not exceed four (4) hours
- any specific measures for ensuring the patient's safety, health and well-being beyond standard Nursing Policies and Procedures, if applicable
- level of observation
- clinical justification for use
- behavioral criteria for release; and
- signature, date and time.

Contraindications: If the physician determines that the clinical benefits of seclusion or restraint outweigh any contraindications, the order must:

- document the risk in the clinical record, and
- require the nursing staff to flag the record accordingly
- the order must specify any additional or increased frequency of RN assessment.

Duration of the Order: The physician's order may authorize the use of seclusion or mechanical restraint for no more than 4 hours.

New Orders: The physician may write a new order at the end of the time period designated in the initial order if:

- the patient is not exhibiting the required release behaviors, and after a face-to-face assessment of the patient, the physician believes restraint or seclusion is still necessary; OR
- if the patient exhibits escalating behavior that is not related to the behaviors that prompted the initial mechanical restraint or seclusion order; OR
- if the patient exhibits escalating behavior and it is more than thirty (30) minutes after release of the patient from seclusion or restraint.

When writing a new order for restraint, the physician must consider ordering a less restrictive restraint device, or an alternative intervention, that could be used to address the patient's behavior.

Separate O

- mechanical devices are used to move a patient into seclusion; OR
- for escalating behaviors not related to the behaviors that initiated the original mechanical restraint or seclusion order; OR
- for escalating behaviors that occur beyond thirty (30) minutes after release; OR
- Clothing articles not specified in nursing procedure, or prosthetic devices such as eyeglasses or hearing aids are removed.

Initiating physical intervention in absence

O Prior to the physical intervention, all efforts possible are to be made to verbally de-escalate the situation.

O When a physician or RN is not present and a behavioral emergency

of physician

- Security staff, when away from patient buildings, may utilize flex cuff or hand cuffs during transportation in an emergency. Such use does not require a physician's order. Upon return to the unit, patient will be assessed by RN or physician for need for further intervention and document in clinical record. Use of cuffs will be documented in the Security Report stating justification, time applied and removed.

- Once a physical intervention is applied:
  - staff must immediately contact a physician or an RN
  - the physician or RN must personally assess the patient within ten (10) minutes of his being physically restrained; and
  - the physician or RN must make a determination of the need for mechanical restraints or seclusion or release of the patient.

- The physician or RN must document in the clinical record:
  - justification for initiating physical intervention
  - names of staff who participated in applying the physical intervention
  - time, location, environmental conditions, ongoing activities and antecedent behaviors of the patient
  - less restrictive interactions attempted by the staff, and
  - the outcome of each less restrictive measure attempted.

Initiating seclusion or mechanical restraint:

Initiating Seclusion or Mechanical Restraint: An RN may initiate seclusion or mechanical restraint in an emergency when a physician is not immediately available. When doing so, the RN must within 10 minutes:

- conduct a clinical and physical assessment of the patient
- check for the correct application of restraints
- initiate required observations: (1:1 or direct)
- notify the physician to obtain an order.

RN Documentation: The RN who determined that seclusion or mechanical restraint was necessary must document in the clinical record:

- justification for initiating the restriction in the absence of a physician
- antecedent behaviors of the patient, less restrictive interactions attempted and the outcome of each less restrictive measure attempted
- result of the physical assessment of the patient
- physician notified and the time of notification; and
- names of staff who participated in implementing seclusion or mechanical restraint.

Physician Assessment and Determination: The physician must, within hour of being notified by the RN:

- personally assess the patient and determine if an order for seclusion of restraint is required AND
- if required, write an order authorizing the use of seclusion or mechanical restraint, document in the clinical record the date and time, and sign the order OR

- if not required, immediately release the patient and document in the clinical record, the justification for this decision, the date and time, and sign the order.
  The initial order authorizing the use of seclusion or mechanical restraint, shall not permit the patient to be held in seclusion or mechanical restraint for more than 4 hours from the initiation of seclusion or mechanical restraint. The time the patient is in seclusion/restraint prior to the physician assessment must be included in the telephone/verbal order.

Placing patients in seclusion or mechanical restraints

- O Patients may only be restrained in accordance with the Hospital Restraint Formulary.
- O A thorough search must be conducted of all patients before they are secluded or placed in mechanical restraints to ensure that contraband and any other potentially dangerous objects are removed from the patient.
- O All potentially dangerous objects, excluding contraband, removed from the patient will be stored in a safe place, and returned to the patient when the patient is assessed to be safe and appropriate. Contraband will be given to the Security Department for disposition.
- O The names of staff members involved in implementing the seclusion or restraint will be documented in the clinical record.

Monitoring requirements:

Seclusion: All patients in seclusion will be on constant observation and staff will be stationed directly outside the seclusion room door.

Mechanical Restraints: All patients in mechanical restraints will be on constant, direct or 1:1observation. Under no circumstances will staff be more than arms length away from a patient on 1:1 observation.

Transport Restraints: Monitoring requirements will be identified by the physician and included in the written order.

Identified Contraindications: Constant observation by nursing staff is required whenever the physician's assessment determines that the clinical benefits of seclusion or mechanical restraint outweigh identified contraindications.

Staff Documentation: Staff will document their observations of the patient in the clinical record every fifteen (15) minutes via WSH form #624, Special Observation Flow Sheet.

RN Assessments: Patients in seclusion or mechanical restraints will be observed and assessed at least hourly by an RN. The RNs observations and assessments will be documented in the clinical record in the ID notes.

The RN's observation/assessment will include a physical assessment, which specifically refers to:

- the patient's level of consciousness or behavior
- the patient's respiratory status
- the patients skin color and
- condition of the patient's limbs, if restrained.

Any change of the patients's level of consciousness or responsiveness (e.g., sleep, drowsiness) noted by any member of the nursing staff requires a reassessment by the RN, who will evaluate the continued need for mechanical restraints or seclusion and the need for a physician's assessment.

Patient care during seclusion or restraint:

During any episode of seclusion or restraint, patient care will be provided, as clinically appropriate, in each of the following areas:

- nutrition per hospital meal plan
- bathing every twenty-four (24) hours, more often if needed
- toileting every 2 hours or as needed
- exercise/range of motion every 2 hours
- therapeutic interventions
- medication, and
- hydration every hour.

Staff will document, in the clinical record, their involvement in meeting the patient's needs, as identified above, and the patient's response to the care provided.

Review requirements:

After the patient has been placed in mechanical restraints or seclusion, a designated staff person will discuss with the patient

- the specific behaviors that necessitated restraint or seclusion
- how the patient's behavior continues to meet the criteria
- the behaviors that must be demonstrated for release or for a reduction in mechanical restraint, and
- the patient's suggestions for how staff can assist him to gain release from mechanical restraint or seclusion.

Staff must document in the clinical record:

- their attempts to communicate this information to the patient
- the patient's response to the intervention, and
- any difficulites the patient has in understanding the information being communicated by the staff person.

Release from seclusion or mechanical restraint:

O

- staff must immediately report this determination to the RN AND
- the RN or a physician will evaluate the patient to determine if release criteria have been met (i.e., the patient is exhibiting the required behaviors) and if the patient is ready for release.

The determination for release must be based on the patients' present behavior. A determination that a patient who is exhibiting the required behaviors is not ready for release must be documented in the clinical record with justification.

O Staff must take actions to facilitate the patient's re-entry into the social milieu following release from restraint or seclusion. Staff will:

- observe the patient for at least fifteen (15) minutes and document the patient's comments in the clinical record
- provide the patient with an appropriate transition and the opportunity to return to activities; and
- give the patient an opportunity to discuss the experience privately with member(s) of the treatment team and document the patient's response in the clinical record.

O The patient will be given an opportunity to discuss the experience with the treatment team at the next scheduled treatment team meeting. The patient's input will be documented in the clinical record.

O If the patient has consented, designated staff will communicate with the legally authorized representative about the seclusion or restraint on the next work day and document this communication in the clinical record.

Reinstating seclusion or mechanical restraint:

Reinstating Seclusion or Restraint Under Existing Order: The RN or physician may reinstate seclusion or restraint under an existing order if:

- the patient's behavior escalates within 30 minutes of release from seclusion and/or mechanical restraint; AND
- the clinical record clearly indicates that the escalating behavior is part of the same episode that prompted the initial order; AND
- the time of the original order has not expired.

New Physician's Order Required: A new physician's order must be written for escalating behavior that:

- is not related to the behaviors that prompted the initial mechanical restraint or seclusion order OR
- occur beyond thirty (30) minutes after release.

When writing a new order for mechanical restraint, the physician must consider ordering a less restrictive restraint device or an alternative intervention that could be used to address the patient's behavior.

Performance Improvement:

O The treatment team will review and modify the treatment plan and its implementation for all patient's who, within a 7 day period, have had more than:
- 2 episodes of seclusion and/or restraint or
- twelve (12) hours of seclusion and/or restraint.

The treatment team will identify factors that precipitate, sustain, or reinforce the patient's dangerous behavior and specify treatment plan interventions to reinforce alternative behaviors and reduce dangerous behaviors.

O The Hospital's medical director will review the treatment of any patient secluded or restrained for twelve (12) continuous hours.

O The Hospital's Behavior Management Committee will conduct a review of the treatment strategy of patients who have been secluded or restrained:
- 3 times in any seven day period, or
- for more than twelve (12) hours in any seven day period.

O The hospital's Behavior Management Committee will consider use of outside consultation if a patient has within a 30 day period been secluded/restrained:
- 12 times or,
- for more than 48 hours

O The Hospital Human Rights Advocate will be notified of who has been mechanically restrained or secluded by forwarding a completed WSH form #137, Report to the Advocate.

O The Hospital leadership will examine monthly trends in seclusion/ restraint use and will take appropriate action to ensure that the use of seclusion and restraint throughout the hospital is limited to the least restrictive intervention necessary.

- Data collection and analysis will include patient and aggregate review by unit, by shift, by type of staff, by ordering physician, as well as multiple episodes by patient.
- Data will be reported by number of episodes, by patients, by hours (duration), and by rate (hours ordered/ 1000 patient hours.)

References:

- Rules and Regulations to Assure the Rights of Patients in Facilities Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services
- Hospital Accreditation Standards, Joint Commission on Accredition of Health Care Organizations (JCAHO)
- DI # Emergency Use of S/R
- DI # 104
- DI #107
- MANDT Training Manual
- H.I. 4010
- H.I. 4011

Decision:

Hospital Instruction No. 4015, dated January 1, 1984, revised September 15, 1985, September 1, 1988, April 1, 1989, April 1, 1991, August 15, 1997, September 24, 1997, June 1, 1998, September 1, 1998.

Approval:

_____
M.D.
Facility Director

Effective Date: 1/4/00

WESTERN STATE HOSPITAL
RESTRAINT FORMULARY

APPROVED RESTRAINT DEVICES:

Only Posey manufactured devices will be used as follows:

Leather wrist
Leather ankle
Leather connecting belts
Leather bed restraints – wrist and ankle

Cloth limb holders
Cloth vest
Cloth soft belt
Cloth pelvic holder

APPROVED METHODS:

2 pt ambulatory: 1 leather restraint to each wrist secured to connecting belt at waist level.

2. 4 pt ambulatory: leather restraint to each wrist secured to connecting belt at waist level and 1 leather restraint to each ankle connected with leather belt sufficiently long enough to allow patient to take short steps.

3. 2 pt. transport: 1 leather restraint to each wrist secured to connecting belt at wrist level or to each ankle secured with a connecting leather belt sufficiently long enough to allow patient to take short steps (order must specify wrist or ankle).

4. 4 pt transport: 1 leather restraint to each wrist secured to connecting belt at waist level and 1 leather restraint to each ankle connected with leather belt sufficiently long enough to allow patient to take short steps.

5. 4 point to chair: leath

6. 4 point with vest (or pelvic holder, or soft belt): same as above with added vest or pelvic holder secured to chair.

7 4 point to bed: 1 leather bed restraint to each wrist and each ankle secured to bed. May use connecting belt from ankle bed strap to foot of bed frame to prevent excessive leg movement. Patient will be restrained face up with wedge support under upper body not to exceed 20 degree elevation

8. 4 point to bed with vest (or pelvic holder, or soft belt): 1 leather bed restraint to each wrist and each ankle secured to bed. May use connecting belt from ankle bed strap to foot of bed frame to prevent excessive leg movement. Posey vest pelvic holder or soft belt may be added when clinically indicated to prevent exaggerated or excessive body movements. Patient will be restrained face up with a wedge support under upper body not to exceed 20 degrees elevation.

Any restraint for more than 4 points require approval of the Medical Director or Facility Director.

9. 6 point to chair: 1 leather restraint to each wrist and each ankle secured to chair arms and legs and 1 to each biceps with connecting belt crisscrossed and attached to chair behind patient.

10. 6 point to bed: 1 leather bed restraint to each wrist and each ankle secured to bed. 1 leather restraint to each biceps secured to bed frame by leather belt. Patient will be restrained face up with a wedge support under upper body not to exceed 20 degrees elevation.

11. 6 point to bed with vest (or pelvic holder, or soft belt): 1 leather bed restraint to each wrist and each ankle secured to bed. 1 leather restraint to each biceps secured to bed frame by leather belt. May use connecting belt from ankle bed strap to foot of bed frame to prevent excessive movement. Posey vest pelvic holder or soft belt may be added when clinically indicated to prevent excessive body movements. Patient will be restrained face up with wedge support under upper body not to exceed 20 degrees elevation.

_____, MD
Facility Director

12/22/99

APPENDIX B DRVD SECLUSION/RESTRAINT USAGE REVIEW FORMS

B

DRVD Seclusion/Restraint Usage Review Form

Client Name: Hospital: WSH Ward: B-2

Date of Incident: 3/28/2000 Time In: 1225 Time Out: 1345

Seclusion / (Restraint) / Both (circle one) Type of restraint 4-pt to chair (in open seclusion room)

Shift: ☑ 7-3 ☐ 3-11 ☐ -7 Weekend? ☐ yes ☐ no

Name and Title of Staff Involved

___ RN

Security staff

PRIOR TO INCIDENT:

Is there evidence of escalation of a behavior which resulted in an earlier intervention?

☐ yes ☑ no

if yes, did behavior begin the: ☐ previous day ☐ same day ☐ same shift

What intervention was used before the current s/r intervention?

☐ change in meds ☐ PRN meds (offered) ☐ PRN meds (forced)
☐ verbal redirection ☐ physical separation of individual from source of friction
☐ voluntary time-out ☐ forced time-out ☐ seclusion
☐ restraint (type _____)

When did intervention begin?

☐ previous day ☐ same day ☐ same shift

Was individual on special precautions? ☐ yes ☑ no

If yes, which ones ☐ suicide ☐ homicide ☐ arson ☐ sexual predator ☐ escape

What interventions were used *prior* to initiating this s/r?

☑ PRN meds (offered) ☐ PRN meds (forced)
☑ verbal redirection ☑ physical separation of individual from source of friction
☑ voluntary time-out ☐ forced time-out ☐ seclusion

S/R INCIDENT

Documentation of reasons for S/R in chart:

- ID notes: "pt continues to be angry and punched another patient in (L) arm.

MD notes: "dangerous physically aggressive non-redirectable behavior (assaulted another patient) AND continues to attempt further aggression"

Does documented behavior meet definition for "emergency"? ☐ yes ☑ no

- If yes, ☐ Danger to Self ☐ Danger to Others ☐ Both

- If no, was S/R used for: ☑ punishment ☐ convenience of staff ☐ ILO treatment pt. did punch a peer, but staff successfully removed pt. to east dayroom away from this peer where pt. ate lunch; he was told not to leave the east dayroom & when he did so, he was "escorted to open seclusion room where 4point leather chair restraints were applied" - this behavior was out of control earlier but notes indicate the he was calm enough to eat his lunch before he ventured into the west dayroom

S/R was abusive because:

☐ No/inadequate clinical justification for use.

☐ Excessive force was used. If so, by whom? Nature of force? Injury?

☐ Medical or psychiatric contraindications existed. If so, describe

ASSESSMENT – HOSPITAL POLICY

Is doctor's order in file? ☑ yes ☐ no

Did doctor see patient and assess *before* initiating order? ☑ yes ☐ no

Was client monitored throughout S/R? ☑ yes ☐ no

Was monitor same gender? ☐ yes ☐ no ?
If not, why not?

Did doctor see patient during S/R? ☑ yes ☐ no

Does chart document checks as required by policy?
Q15 ☑ yes ☐ no VS ☐ yes ☑ no
Range of Motion ☐ yes ☑ no ☐ N/A due to limited period of S/R

was patient offered opportunity to use toilet? ☑ yes ☐ no

was patient offered water? ☑ yes ☐ no

was patient offered food? ☐ yes ☐ no ☑ N/A due to time of day

Did S/R order specify behaviors necessary for release? ☑ yes ☐ no

Was the reason for being placed in s/r clearly communicated to patient? ☐ yes ☑ no

Was criteria for discharge clearly communicated to patient? ☐ yes ☑ no

MEDS

Was patient taking prescribed psychiatric medication in the period preceding the incident? ☑ yes ☐ no

Was a PRN used *after* the patient was placed in s/r? ☐ yes ☑ no

What was the clinical justification for *both* chemical and mechanical restraints?

RELEASE

If seclusion used and individual went to sleep, was door unlocked and opened?
☐ yes ☑ no
If not, why?

If restrained, was individual released upon falling asleep? ☑ yes ☐ no
If not, why?

Was individual released within 5 minutes of exhibiting "release behaviors"?
☑ yes ☐ no

Who assessed patient for release? How documented?
, RN and Dr. `IO note

How was patient monitored after release? "to be monitored to assure pt has ø aggressive behavior."

CONSULTATIONS AND BEHAVIOR PLANS

If patient was in s/r within the month prior to this incident, was a consultation sought?
☐ yes ☐ no

If yes, for which? ☐ Psychopharmacology ☐ Behavior

Was treatment plan modified to address identified problem behaviors? ☐ yes ☐ no

Was a behavior plan developed? ☐ yes ☐ no

Was patient involved in planning? ☐ yes ☐ no

Were changes/ new plan implemented? ☐ yes ☐ no

What behaviors resulted?

PATIENT'S COMMENTS

OTHER issues identified:

☐ appropriateness of medications

☐ informed consent/treatment over objection

☐ other

DRVD Seclusion/Restraint Usage Review Form

Client Name: Hospital: WSH Ward: A-4

Date of Incident: 3/9/2000 Time In: 2230 Time Out: 2345

Seclusion / Restraint / Both (circle one) Type of restraint 4-pt to bed

Shift: ☐ 7-3 ☑ 3-1 ☐ 11-7 Weekend? ☐ yes ☐ no

Name and Title of Staff Involved:

Security Personnel, PPN
, RN
, RN

PRIOR TO INCIDENT:

Is there evidence of escalation of a behavior which resulted in an earlier intervention?
☐ yes ☑ no
if yes, did behavior begin the: ☐ previous day ☐ same day ☐ same shift

What intervention was used before the current s/r intervention?
☐ change in meds ☐ PRN meds (offered) ☐ PRN meds (forced)
☐ verbal redirection ☐ physical separation of individual from source of friction
☐ voluntary time-out ☐ forced time-out ☐ seclusion
☐ restraint (type _____)

When did intervention begin?
☐ previous day ☐ same day ☐ same shift

Was individual on special precautions? ☐ yes ☑ no
If yes, which ones ☐ suicide ☐ homicide ☐ arson ☐ sexual predator ☐ escape

What interventions were used *prior* to initiating this s/r?
refused ☐ PRN meds (offered) ☐ PRN meds (forced)
☑ verbal redirection ☐ physical separation of individual from source of friction
☑ voluntary time-out refused ☐ forced time-out ☐ seclusion

S/R INCIDENT

Documentation of reasons for S/R in chart:

- ID notes: pt attempted to break door leading to nursing station while verbally threatening "I am going to fucking kill you" → led to order for seclusion
  "kicked security while being placed in restraints" → led to order for restraints
- MD notes: "violent / threatening behavior towards staff and peers" — seems to have actually occurred when security was escorting pt to seclusion
  no indication of aggression toward peers

Does documented behavior meet definition for "emergency"? ☑ yes ☐ no

- If yes, ☐ Danger to Self ☑ Danger to Others ☐ Both

- If no, was S/R used for: ☐ punishment ☐ convenience of staff ☐ ILO treatment

S/R was abusive because:

☐ No/inadequate clinical justification for use.

☐ Excessive force was used. If so, by whom? Nature of force? Injury?

☐ Medical or psychiatric contraindications existed. If so, describe

ASSESSMENT – HOSPITAL POLICY

Is doctor's order in file? ☑ yes ☐ no

Did doctor see patient and assess *before* initiating order? ☐ yes ☑ no

Was client monitored throughout S/R? ☑ yes ☐ no

Was monitor same gender? ☐ yes ☐ no ?
If not, why not?

Did doctor see patient during S/R? ☐ yes ☑ no

Does chart document checks as required by policy?

Q15 ☑ yes ☐ no VS ☐ yes ☑ no
Range of Motion ☐ yes ☐ no ☑ N/A due to limited period of S/R

was patient offered opportunity to use toilet? ☐ yes ☑ no

was patient offered water? ☐ yes ☑ no

was patient offered food? ☐ yes ☐ no ☑ N/A due to time of day

Did S/R order specify behaviors necessary for release? ☑ yes ☐ no

Was the reason for being placed in s/r clearly communicated to patient? ☐ yes ☑ no

Was criteria for discharge clearly communicated to patient? ☐ yes ☑ no

MEDS

Was patient taking prescribed psychiatric medication in the period preceding the incident? ☑ yes ☐ no

Was a PRN used *after* the patient was placed in s/r? ☑ yes ☐ no

Haldol 5mg IM, Ativan 2mg, Cogentin 1mg given over objection

What was the clinical justification for *both* chemical and mechanical restraints?

pt. kicked security officer during restraint application

RELEASE

If seclusion used and individual went to sleep, was door unlocked and opened?

☐ yes ☐ no

If not, why?

If restrained, was individual released upon falling asleep? ☐ yes ☐ no

If not, why?

Was individual released within 15 minutes of exhibiting "release behaviors"?

☑ yes ☐ no

Who assessed patient for release? How documented?

RN IO note

How was patient monitored after release? V/d Q30min

CONSULTATIONS AND BEHAVIOR PLANS

If patient was in s/r within the month prior to this incident, was a consultation sought?

☐ yes ☐ no

If yes, for which? ☐ Psychopharmacology ☐ Behavior

Was treatment plan modified to address identified problem behaviors? ☐ yes ☐ no

Was a behavior plan developed? ☐ yes ☐ no

Was patient involved in planning? ☐ yes ☐ no

Were changes/ new plan implemented? ☐ yes ☐ no

What behaviors resulted?

PATIENT'S COMMENTS

OTHER issues identified:

☐ appropriateness of medications

☐ informed consent/treatment over objection

☐ other

prison

B-8

DRVD Seclusion/Restraint Usage Review Form

Client Name: Hospital WSH Ward: A4 & cont. on A6

Date of Incident: 2/18/2000 Time In 9:30 AM Time Out: 1:20 pm

Seclusion / Restraint / (Both) (circle one) Type of restraint 4-pt amb. w/waist belt (only for transport from A4 to A6; time in restraints was 10 minutes — rest of the time in seclusion)

Shift: ☑ 7-3 ☐ 3-11 ☐ 11-7 Weekend? ☐ yes ☐ no

Name and Title of Staff Involved:

Dr. , MD , RN security personnel (,) , PPN , RN

Dr. , MD , RN , PA

PRIOR TO INCIDENT:

Is there evidence of escalation of a behavior which resulted in an earlier intervention?

☐ yes ☑ no

if yes, did behavior begin the: ☐ previous day ☐ same day ☐ same shift

What intervention was used before the current s/r intervention?

☐ change in meds ☐ PRN meds (offered) ☐ PRN meds (forced)

☐ verbal redirection ☐ physical separation of individual from source of friction

☐ voluntary time-out ☐ forced time-out ☐ seclusion

☐ restraint (type _____)

When did intervention begin?

☐ previous day ☐ same day ☐ same shift

Was individual on special precautions? ☐ yes ☑ no

If yes, which ones ☐ suicide ☐ homicide ☐ arson ☐ sexual predator ☐ escape

What interventions were used *prior* to initiating this s/r?

☐ PRN meds (offered) ☐ PRN meds (forced)

☑ verbal redirection ☐ physical separation of individual from source of friction

☐ voluntary time-out ☐ forced time-out ☐ seclusion

↳ after restraints were removed on A-6

- doors were locked at 11:25 due to striking out, kicking & resisting security officers

S/R INCIDENT

Documentation of reasons for S/R in chart:

- ID notes: "uncooperative w/ going to off ward treatment program this AM. Angry, threatening statements toward staff"
- MD notes: r. present
  - no reason given for use of restraint other than "for transport"
  - reason given for seclusion → physically aggressive behavior

Does documented behavior meet definition for "emergency"? ☐ yes ☑ no

- If yes, ☐ Danger to Self ☐ Danger to Others ☐ Both
- If no, was S/R used for: ☑ punishment ☑ convenience of staff ☐ ILO treatment

S/R was abusive because:

☑ No/inadequate clinical justification for use. pt. just made verbal threats - no physical aggression noted

☐ Excessive force was used. If so, by whom? Nature of force? Injury?

☐ Medical or psychiatric contraindications existed. If so, describe

ASSESSMENT – HOSPITAL POLICY

Is doctor's order in file? ☑ yes ☐ no

Did doctor see patient and assess *before* initiating order? ☑ yes ☐ no

Was client monitored throughout S/R? ☑ yes ☐ no

Was monitor same gender? ☐ yes ☐ no ?

If not, why not?

Did doctor see patient during S/R? ☑ yes ☐ no

Does chart document checks as required by policy?

Q15 ☑ yes ☐ no VS ☐ yes ☑ no

Range of Motion ☐ yes ☐ no ☑ N/A due to limited period of S/R

was patient offered opportunity to use toilet? ☑ yes ☐ no

was patient offered water? ☑ yes ☐ no

was patient offered food? ☑ yes ☐ no ☐ N/A due to time of day

Did S/R order specify behaviors necessary for release? ☑ yes ☐ no

Was the reason for being placed in s/r clearly communicated to patient? ☐ yes ☑ no

Was criteria for discharge clearly communicated to patient? ☑ yes ☑ no

MEDS

Was patient taking prescribed psychiatric medication in the period preceding the incident? ☑ yes ☐ no

Was a PRN used *after* the patient was placed in s/r? ☑ yes ☑ no [redacted]

What was the clinical justification for *both* chemical and mechanical restraints?

None - when pt finally accepted PRN Thorazine, notes indicate "at this same time was calm enough to listen to criteria for release..."

RELEASE

If seclusion used and individual went to sleep, was door unlocked and opened?

☑ yes ☐ no

If not, why?

If restrained, was individual released upon falling asleep? ☐ yes ☐ no

If not, why?

Was individual released within 15 minutes of exhibiting "release behaviors"?

☑ yes ☐ no

Who assessed patient for release? How documented?

- cannot read person's name Is note

How was patient monitored after release? not indicated

CONSULTATIONS AND BEHAVIOR PLANS

If patient was in s/r within the month prior to this incident, was a consultation sought?

☐ yes ☐ no

If yes, for which? ☐ Psychopharmacology ☐ Behavior

Was treatment plan modified to address identified problem behaviors? ☐ yes ☐ no

Was a behavior plan developed? ☐ yes ☐ no

Was patient involved in planning? ☐ yes ☐ no

Were changes/ new plan implemented? ☐ yes ☐ no

What behaviors resulted?

PATIENT'S COMMENTS

OTHER issues identified:

☐ appropriateness of medications

☐ informed consent/treatment over objection

☐ other

DRVD Seclusion/Restraint Usage Review Form

B-1 ✓

* pt much more likely to get secluded/restrained if Dr. present when behavior began day. if Dr. is the target of pt's anger

Client Name: Hospital: WSH Ward A-4 and cont. on A-6

Date of Incident: 2/17/2000 Time In: 0930 Time Out: 1130

Seclusion / Restraint / Both (circle one) Type of restraint 2-pt wrist to waist ambulatory for transport from A-4 to A-6

Shift: ☑ 7-3 ☐ 3-11 ☐ 11-7 Weekend? ☐ yes ☐ no (time in restraint 20 minutes)

Name and Title of Staff Involved:

All were present during transfer

Dr. MD, HBCW
Security personnel (3), HSCW
, RN, PPN
, RN, HSCW
Security

PRIOR TO INCIDENT:

Is there evidence of escalation of a behavior which resulted in an earlier intervention?
☐ yes ☑ no
if yes, did behavior begin the: ☐ previous day ☐ same day ☐ same shift

What intervention was used before the current s/r intervention?
☐ change in meds ☐ PRN meds (offered) ☐ PRN meds (forced)
☐ verbal redirection ☐ physical separation of individual from source of friction
☐ voluntary time-out ☐ forced time-out ☐ seclusion
☐ restraint (type _____)

When did intervention begin?
☐ previous day ☐ same day ☐ same shift

Was individual on special precautions? ☐ yes ☑ no
If yes, which ones ☐ suicide ☐ homicide ☐ arson ☐ sexual predator ☐ escape

What interventions were used *prior* to initiating this s/r?
☐ PRN meds (offered) ☐ PRN meds (forced)
☑ verbal redirection ☐ physical separation of individual from source of friction
☐ voluntary time-out ☐ forced time-out ☐ seclusion

S/R INCIDENT

Documentation of reasons for S/R in chart:

- ID notes: "very agitated, angry, and out of control" "Was going to come in the office in (nursing) office room 200 after Dr. ." - "by doctor report, he attempted to push his way into the office to physically attack the doctor"
- MD notes: Aggressive & threatening behavior

Does documented behavior meet definition for "emergency"? ☐ yes ☑ no

- If yes, ☐ Danger to Self ☐ Danger to Others ☐ Both

- If no, was S/R used for: ☑ punishment ☐ convenience of staff ☐ ILO treatment

S/R was abusive because:

☐ No/inadequate clinical justification for use.

☑ Excessive force was used. If so, by whom? Nature of force? Injury?
when pt got angry, doctor came into hallway & told pt he had to go to AL tx mall - pt got angry @ doctor and followed doctor as he walked back to the nursing office - doctor called security & had pt restrained for transport to AL - 20 minutes later pt was calm on AL, but still received 2 Y medo IM over objection.

☐ Medical or psychiatric contraindications existed. If so, describe

ASSESSMENT – HOSPITAL POLICY

Dr. came onto ward while pt was eating lunch & told him that he would rec. add'l restriction time and would have to attend AL as a consequence of his behavior - pt did not make eye contact & just kept eating.

Is doctor's order in file? ☑ yes ☐ no

Did doctor see patient and assess *before* initiating order? ☑ yes ☐ no

Was client monitored throughout S/R? ☑ yes ☐ no

Was monitor same gender? ☐ yes ☐ no ?
If not, why not?

Did doctor see patient during S/R? ☑ yes ☐ no

Does chart document checks as required by policy?

Q15 ☑ yes ☐ no VS ☐ yes ☐ no
Range of Motion ☐ yes ☐ no ☐ N/A due to limited period of S/R

was patient offered opportunity to use toilet? ☑ yes ☐ no

B-4
✓

DRVD Seclusion/Restraint Usage Review Form

Client Name: Hospital: WSH Ward: A-4

Date of Incident: 2/5/2000 Time In: 0045 Time Out: 2:30 AM

Seclusion / Restraint / Both (circle one) Type of restraint 4-pt to bed

Shift: ☐ 7-3 ☐ 3-11 ☑ 11-7 Weekend? ☐ yes ☐ no

Name and Title of Staff Involved:

, RN
, ?

PRIOR TO INCIDENT:

Is there evidence of escalation of a behavior which resulted in an earlier intervention?
☐ yes ☑ no
if yes, did behavior begin the: ☐ previous day ☐ same day ☐ same shift

What intervention was used before the current s/r intervention?
☐ change in meds ☐ PRN meds (offered) ☐ PRN meds (forced)
☐ verbal redirection ☐ physical separation of individual from source of friction
☐ voluntary time-out ☐ forced time-out ☐ seclusion
☐ restraint (type _____)

When did intervention begin?
☐ previous day ☐ same day ☐ same shift

Was individual on special precautions? ☑ yes ☐ no
If yes, which ones ☑ suicide ☐ homicide ☐ arson ☐ sexual predator ☐ escape

What interventions were used *prior* to initiating this s/r?
☑ PRN meds (offered) ☑ PRN meds (forced)
☑ verbal redirection ☐ physical separation of individual from source of friction
☐ voluntary time-out ☐ forced time-out ☐ seclusion

S/R INCIDENT

Documentation of reasons for S/R in chart:

- ID notes: violent behavior - throwing furniture, physical & verbal threats
- MD notes: aggressive, violent & threatening behavior

Does documented behavior meet definition for "emergency"? ☑ yes ☐ no

- If yes, ☐ Danger to Self ☐ Danger to Others ☐ Both

If no, was S/R used for: ☐ punishment ☐ convenience of staff ☐ ILO treatment

S/R was abusive because:

☐ No/inadequate clinical justification for use.

☐ Excessive force was used. If so, by whom? Nature of force? Injury?

☐ Medical or psychiatric contraindications existed. If so, describe

ASSESSMENT – HOSPITAL POLICY

Is doctor's order in file? ☑ yes ☐ no

Did doctor see patient and assess *before* initiating order? ☐ yes ☑ no

Was client monitored throughout S/R? ☑ yes ☐ no

Was monitor same gender? ☐ yes ☐ no ?
If not, why not?

Did doctor see patient during S/R? ☑ yes ☐ no

Does chart document checks as required by policy?

Q15 ☑ yes ☐ no VS ☑ yes ☐ no

1:1 direct observation · Range of Motion ☑ yes ☐ no ☐ N/A due to limited period of S/R

was patient offered opportunity to use toilet? ☑ yes ☐ no

was patient offered water? ☑ yes ☐ no

was patient offered food? ☐ yes ☐ no ☑ N/A due to time of day

Did S/R order specify behaviors necessary for release? ☑ yes ☐ no

Was the reason for being placed in s/r clearly communicated to patient? ☐ yes ☑ no

Was criteria for discharge clearly communicated to patient? ☐ yes ☑ no

MEDS

Was patient taking prescribed psychiatric medication in the period preceding the incident? ☑ yes ☐ no

Was a PRN used *after* the patient was placed in s/r? ☐ yes ☑ no

What was the clinical justification for *both* chemical and mechanical restraints?

RELEASE

If seclusion used and individual went to sleep, was door unlocked and opened?
☐ yes ☑ no
If not, why?

If restrained, was individual released upon falling asleep? ☐ yes ☑ no
If not, why? note indicates he began snoring at 1:45 but was not released until 2:30 AM. - no explanation given

Was individual released within 15 minutes of exhibiting "release behaviors"?
☐ yes ☑ no order called for 30' of calm but he was released 45 min. after he was heard snoring

Who assessed patient for release? How documented?
RN IO note

How was patient monitored after release? direct observation for self-harm

CONSULTATIONS AND BEHAVIOR PLANS

If patient was in s/r within the month prior to this incident, was a consultation sought?
☐ yes ☐ no

If yes, for which? ☐ Psychopharmacology ☐ Behavior

Was treatment plan modified to address identified problem behaviors? ☐ yes ☐ no

Was a behavior plan developed? ☐ yes ☐ no

Was patient involved in planning? ☐ yes ☐ no

Were changes/ new plan implemented? ☐ yes ☐ no

What behaviors resulted?

PATIENT'S COMMENTS

OTHER issues identified:

☐ appropriateness of medications

☐ informed consent/treatment over objection

☐ other

DRVD Seclusion/Restraint Usage Review Form

Client Name: Admitted WSH Hospital: WSH Ward: B-2

Date of Incident: 3/14/00 Time In: 0300 Time Out: 1430

Seclusion / (Restraint) / (Both) (circle one) Type of restraint 4 pt to bed

Shift: ☒ 7-3 ☐ 3-11 ☐ 11-7 Weekend? ☐ yes ☐ no

Name and Title of Staff Involved: RN HSC PPN PA PA PA

PRIOR TO INCIDENT:

Is there evidence of escalation of a behavior which resulted in an earlier intervention?

☑ yes ☐ no

if yes, did behavior begin the: ☒ previous day ☐ same day ☐ same shift

uncontrolled psychosis, meds being adjusted per documented plan
pt. tried to climb fence

What intervention was used before the current s/r intervention?

☒ change in meds ☒ PRN meds (offered) ☒ PRN meds (forced)
☒ verbal redirection ☐ physical separation of individual from source of friction
☐ voluntary time-out ☐ forced time-out ☐ seclusion
☐ restraint (type _____)

Dr. met w/ pt. previous day to discuss his fears/delusions - reviewed meds & modified per plan

When did intervention begin?

☒ previous day ☐ same day ☐ same shift

Was individual on special precautions? ☐ yes ☒ no

If yes, which ones ☐ suicide ☐ homicide ☐ arson ☐ sexual predator ☐ escape

What interventions were used *prior* to initiating this s/r?

☒ PRN meds (offered) ☐ PRN meds (forced)
☒ verbal redirection ☒ physical separation of individual from source of friction 2 man MANDT to less active site per ID notes
☐ voluntary time-out ☐ forced time-out ☐ seclusion

per SO Flowsheet – Redirect & PRN meds

was patient offered water? ☒ yes ☒ no after hr

was patient offered food? ☐ yes ☒ no ☒ N/A due to time of day
first after lunch

Did S/R order specify behaviors necessary for release? ☒ yes ☐ no

calm 30 min & convincingly contracting not to hurt others

Was the reason for being placed in s/r clearly communicated to patient? ☐ yes ☐ no

Was criteria for discharge clearly communicated to patient? ☐ yes ☐ no

it appears this was done - however, active Ψ symptoms interfere w/ pt understanding - ID note document clearly

MEDS

Was patient taking prescribed psychiatric medication in the period preceding the incident? ☒ yes ☐ no

Patient meds being titrated due to documented need/rationale

Was a PRN used *after* the patient was placed in s/r? ☒ yes ☒ no took P.O.

So flow says no, doctor's note says yes - ID notes say yes meds. vol.

What was the clinical justification for *both* chemical and mechanical restraints?

Doctor had adequate justification for PRNs during med changes. Pt refused vol. prn from nurse prior - continue threatening & delusional while restrained - psychosis (not partic incident) caused flare up

RELEASE

If seclusion used and individual went to sleep, was door unlocked and opened?

☐ yes ☐ no N/A

If not, why?

If restrained, was individual released upon falling asleep? ☐ yes ☐ no

If not, why? N/A

Was individual released within 15 minutes of exhibiting "release behaviors"?

☒ yes ☐ no

Who assessed patient for release? How documented? ID notes RN

How was patient monitored after release? continued reassurance & support

no spec order - several notes in next few hours

offered 1:1 & redirect to quiet as needed

NM 1 (9) ✓

DRVD Seclusion/Restraint Usage Review Form

admit 3/17/2000

Client Name: Hospital: WSH Ward: B-2

Date of Incident: 3/17/100 Time In: 1500 Time Out: (3/18) 0645 15:45 hrs

Seclusion / Restraint / Both (circle one) Type of restraint 4 pt leather amb

Shift: ☐ 7-3 ☒ 3-1 ☒ 11-7 Weekend? ☐ yes ☐ no

Name and Title of Staff Involved:

PRIOR TO INCIDENT:

Is there evidence of escalation of a behavior which resulted in an earlier intervention?

☒ yes ☐ no

if yes, did behavior begin the: ☐ previous day ☐ same day ☐ same shift

behavior resulted in transfer from jail to WSH

What intervention was used before the current s/r intervention?

☐ change in meds ☐ PRN meds (offered) ☐ PRN meds (forced)
☐ verbal redirection ☐ physical separation of individual from source of friction
☐ voluntary time-out ☐ forced time-out ☐ seclusion
☐ restraint (type _____)

When did intervention begin?

☐ previous day ☐ same day ☐ same shift

Was individual on special precautions? ☐ yes ☐ no

If yes, which ones ☐ suicide ☐ homicide ☐ arson ☐ sexual predator ☐ escape

What interventions were used *prior* to initiating this s/r? none - new admission

☐ PRN meds (offered) ☐ PRN meds (forced)
☐ verbal redirection ☐ physical separation of individual from source of friction
☐ voluntary time-out ☐ forced time-out ☐ seclusion

S/R INCIDENT

Documentation of reasons for S/R in chart:

- ID notes: "I don't know if I can be safe behavior during transport" 3/17 1605 pt says he needs to be restraints — Deputies report assaultive
- MD notes: Pt florida Φ, new admission lack of insight, unpredictable — hx of dangerous behaviors

Does documented behavior meet definition for "emergency"? ☐ yes ☒ no

- If yes, ☐ Danger to Self ☐ Danger to Others ☐ Both

- If no, was S/R used for: ☐ punishment ☒ convenience of staff ☐ ILO treatment — used pre-emptively, no imminence demonstrated. Recent incidents w/ police/jail – do not necessarily transfer to new setting

S/R was abusive because:

☒ No/inadequate clinical justification for use.

☐ Excessive force was used. If so, by whom? Nature of force? Injury?

☐ Medical or psychiatric contraindications existed. If so, describe

ASSESSMENT – HOSPITAL POLICY

Is doctor's order in file? ☒ yes ☐ no

Orders updated every 4 hours as required

Did doctor see patient and assess *before* initiating order? ☒ yes ☐ no

Was client monitored throughout S/R? ☒ yes ☐ no

Placed in amb restraints on admission — unable to contract

Was monitor same gender? ☐ yes ☐ no N/A

If not, why not?

Did doctor see patient during S/R? ☒ yes ☐ no 3/17 1850

Does chart document checks as required by policy?

Q15 ☒ yes ☐ no VS ☐ yes ☐ no refused by pt

Range of Motion ☒ yes ☐ no ☐ N/A due to limited period of S/R

1700 2200 2300

was patient offered opportunity to use toilet? ☒ yes ☐ no 630, 1900, 2000 22?

Circ check 1630 1700 #1745 1900, 12000, 2100 2200 2300, 0000, 0100, 0200, 0300 0400 0500 2300, 0030, 0300

was patient offered water? ☒ yes ☐ no 1500, 1530, 1630 1745

was patient offered food? ☒ yes ☐ no ☐ N/A due to time of day 1500, 1530 1730

Did S/R order specify behaviors necessary for release? ☒ yes ☐ no

"calm, organized behavior for 30 min" able to contract for safety

Was the reason for being placed in s/r clearly communicated to patient? ☐ yes ☐ no

pt plans to f/u -

Was criteria for discharge clearly communicated to patient? ☐ yes ☒ no

MEDS

Was patient taking prescribed psychiatric medication in the period preceding the incident? ☐ yes ☒ no

Was a PRN used *after* the patient was placed in s/r? ☐ yes ☐ no 1700, 0000, 3/17 2300 PRN ativan po ordered - IM not required

What was the clinical justification for *both* chemical and mechanical restraints?

RELEASE

If seclusion used and individual went to sleep, was door unlocked and opened? ☐ yes ☐ no

If not, why? N/A

DNS to seclusion room unplugged S/O

If restrained, was individual released upon falling asleep? ☐ yes ☐ no

If not, why? N/A

Awake alert

Was individual released within 15 minutes of exhibiting "release behaviors"? ☒ yes ☐ no

Who assessed patient for release? How documented? ID Notes

How was patient monitored after release? q15' monitor

CONSULTATIONS AND BEHAVIOR PLANS

If patient was in s/r within the month prior to this incident, was a consultation sought?

☐ yes ☐ no N/A

If yes, for which? ☐ Psychopharmacology ☐ Behavior

Was treatment plan modified to address identified problem behaviors? ☐ yes ☐ no

Was a behavior plan developed? ☐ yes ☐ no New admit

Was patient involved in planning? ☐ yes ☐ no 3/20 Risperidone + lorazepam order

Were changes/ new plan implemented? ☐ yes ☐ no

What behaviors resulted?

PATIENT'S COMMENTS

Admission - Pt says he did not understand why he at ESH - although he had no problem w/ amb restraints + seclusion - ~~No chart~~

OTHER issues identified:

☐ appropriateness of medications Used minimal meds until 3/22 and opinion on capacity gotten

☐ informed consent/treatment over objection AR appt'd (mother) 3/29/00 meds, release of info, Hmt

☐ other

Chart notes indicate no efforts to explain legal status to pt or to explain anything

Nm 2 (10) ✓

D Seclusion/Restraint Usage Review Form

Client Name: Hospital: WSH Ward: B-2

Date of Incident: 3/20/00 Time In 1320 Time Out:

Seclusion / ~~Restraint~~ / Both (circle one) Type of restraint 4 pt leather soft restraints to bed

Shift: ☒ 7-3 ☐ 3-11 ☐ 11-7 Weekend? ☐ yes ☐ no

Name and Title of Staff Involved: Dr. order to bathe - RN, RN + Security

PRIOR TO INCIDENT:

Is there evidence of escalation of a behavior which resulted in an earlier intervention?

☐ yes ☐ no

if yes, did behavior begin the: ☐ previous day ☐ same day ☐ same shift

Pt. refusing to bathe, order to bathe over obj triggered incident

What intervention was used before the current s/r intervention?

☐ change in meds ☐ PRN meds (offered) ☐ PRN meds (forced)
☐ verbal redirection ☐ physical separation of individual from source of friction
☐ voluntary time-out ☐ forced time-out ☐ seclusion
☐ restraint (type _____)

When did intervention begin?

☐ previous day ☐ same day ☐ same shift

Was individual on special precautions? ☒ yes ☐ no q 15 checks

If yes, which ones ☐ suicide ☐ homicide ☐ arson ☐ sexual predator ☐ escape

What interventions were used *prior* to initiating this s/r? None

☐ PRN meds (offered) ☐ PRN meds (forced)
☐ verbal redirection ☐ physical separation of individual from source of friction
☐ voluntary time-out ☐ forced time-out ☐ seclusion

redirection & PRN noted not actually given before incident

S/R INCIDENT

Documentation of reasons for S/R in chart:

- ID notes: pt took po meds c/o problem - only when escorted to shower did he balk - attempting to stall staff
- MD notes: Dr noted that orders written by Dr G were observed that pt. may not be able to verbally contract - look at other indicators no less restrictive option

Does documented behavior meet definition for "emergency"? ☒ yes ☐ no

- If yes, ☐ Danger to Self ☐ Danger to Others ☒ Both
  head butting, spitting,
- If no, was S/R used for: ☐ punishment ☐ convenience of staff ☐ ILO treatment

S/R was abusive because:

☐ No/inadequate clinical justification for use.

☐ Excessive force was used. If so, by whom? Nature of force? Injury?

☐ Medical or psychiatric contraindications existed. If so, describe

☒ Triggered by forced bathing - over obj. pt. being restrained cause incident

ASSESSMENT – HOSPITAL POLICY

Is doctor's order in file? ☒ yes ☐ no

Did doctor see patient and assess *before* initiating order? ☐ yes ☐ no

Was client monitored throughout S/R? ☒ yes ☐ no

Was monitor same gender? ☐ yes ☐ no can't tell
If not, why not?

Did doctor see patient during S/R? ☐ yes ☐ no

Does chart document checks as required by policy?

Q15 ☒ yes ☐ no VS ☐ yes ☒ no
Range of Motion ☒ yes ☐ no ☐ N/A due to limited period of S/R
1600

was patient offered opportunity to use toilet? ☒ yes ☐ no
1400 1500 1600

Circ. Check

was patient offered water? ☒ yes ☐ no 1900, 1602

was patient offered food? ☐ yes ☐ no ☒ N/A due to time of day

Did S/R order specify behaviors necessary for release? ☒ yes ☐ no

Was the reason for being placed in s/r clearly communicated to patient? ☐ yes ☒ no

no Doc

Was criteria for discharge clearly communicated to patient? ☒ yes ☐ no

MEDS

Was patient taking prescribed psychiatric medication in the period preceding the incident? ☐ yes ☒ no just started before incident - not time to take effect

Was a PRN used *after* the patient was placed in s/r? ☒ yes ☐ no

Ativan 2 mg IM 1320 & 1525

What was the clinical justification for *both* chemical and mechanical restraints?

none given

RELEASE

If seclusion used and individual went to sleep, was door unlocked and opened?

☐ yes ☐ no N/A

If not, why?

If restrained, was individual released upon falling asleep? ☐ yes ☐ no

If not, why? N/A

Was individual released within 15 minutes of exhibiting "release behaviors"?

☒ yes ☐ no

Who assessed patient for release? How documented? Nurse ID note

How was patient monitored after release? security present at release

Pt prefers open seclusion room to sleep

D 15 checks

CONSULTATIONS AND BEHAVIOR PLANS

If patient was in s/r within the month prior to this incident, was a consultation sought?

☐ yes ☐ no

If yes, for which? ☐ Psychopharmacology ☐ Behavior

Was treatment plan modified to address identified problem behaviors? ☐ yes ☐ no

Was a behavior plan developed? ☐ yes ☐ no

Was patient involved in planning? ☐ yes ☐ no

Were changes/ new plan implemented? ☐ yes ☐ no

What behaviors resulted?

PATIENT'S COMMENTS

OTHER issues identified:

☐ appropriateness of medications

☐ informed consent/treatment over objection

☒ other 3/20/00, 1210 order to "bathe over objecting vol. to maintain minimal hygiene for public safety reasons

Do Not seclude use restraint if needed

Order to bathe over obj. precipitated whole incident

NM ?

DRVD Seclusion/Restraint Usage Review Form

Client Name: Hospital: WSH Ward: B-2

Date of Incident: 3/21/00 Time In: 1345 Time Out:

Seclusion / Restraint / Both (circle one) Type of restraint 4 pt to bed

Shift: ☐ 7-3 ☒ 3-11 ☐ 11-7 Weekend? ☐ yes ☐ no

Name and Title of Staff Involved: RN D. RN

PRIOR TO INCIDENT:

Is there evidence of escalation of a behavior which resulted in an earlier intervention?

☐ yes ☐ no

if yes, did behavior begin the: ☐ previous day ☐ same day ☐ same shift

What intervention was used before the current s/r intervention?

☐ change in meds ☐ PRN meds (offered) ☐ PRN meds (forced)
☐ verbal redirection ☐ physical separation of individual from source of friction
☐ voluntary time-out ☐ forced time-out ☐ seclusion
☐ restraint (type _____)

When did intervention begin?

☐ previous day ☐ same day ☐ same shift

Was individual on special precautions? ☐ yes ☐ no

If yes, which ones ☐ suicide ☐ homicide ☐ arson ☐ sexual predator ☐ escape

What interventions were used *prior* to initiating this s/r?

☒ PRN meds (offered) ☒ PRN meds (forced) IM at 1:00
☒ verbal redirection ☐ physical separation of individual from source of friction
☒ voluntary time-out ☐ forced time-out ☐ seclusion

Amb restraints appear adequate but bed not used

S/R INCIDENT

Documentation of reasons for S/R in chart:

- ID notes: pt refused po meds, went to vol. seclusion, became angry when po meds re-offered - restrained for IM meds, became angrier, unable to redirect so staff could leave, threatening. 4pt amb. to 4pt bed
- MD notes: "pushed staff - offered po ativan - refused physically aggressive toward staff forcing IM meds" - offered seclusion came out wanted apology, dangerous, non-redirectable

Does documented behavior meet definition for "emergency"? ☒ yes ☐ no

- If yes, ☐ Danger to Self ☒ Danger to Others ☐ Both

not clear why amb restraint or chair not used

- If no, was S/R used for: ☐ punishment ☐ convenience of staff ☐ ILO treatment

S/R was abusive because:

☐ No/inadequate clinical justification for use.

☐ Excessive force was used. If so, by whom? Nature of force? Injury?

excessive - amb appears adequate

Amb used only to transport from open seclusion to bed restraint

☐ Medical or psychiatric contraindications existed. If so, describe

ASSESSMENT – HOSPITAL POLICY

Is doctor's order in file? ☒ yes ☐ no

Did doctor see patient and assess *before* initiating order? ☒ yes ☐ no

Was client monitored throughout S/R? ☒ yes ☐ no

Was monitor same gender? ☐ yes ☐ no Can't tell

If not, why not?

Did doctor see patient during S/R? ☐ yes ☒ no

Does chart document checks as required by policy?

Q15 ☒ yes ☐ no VS ☐ yes ☐ no

Range of Motion ☒ yes ☐ no ☐ N/A due to limited period of S/R

1345 1545

1445 1600

was patient offered opportunity to use toilet? ☒ yes ☐ no 1345, 1445

Circ. 1345 1445, 1545, 1600, 1630,

was patient offered water? ☒ yes ☐ no 1345, 1445, 1500, 1530 1630 1645

was patient offered food? ☐ yes ☐ no ☒ N/A due to time of day

Did S/R order specify behaviors necessary for release? ☒ yes ☐ no

Was the reason for being placed in s/r clearly communicated to patient? ☐ yes ☒ no

Was criteria for discharge clearly communicated to patient? ☐ yes ☒ no
not noted initially
noted at 1655

MEDS

Was patient taking prescribed psychiatric medication in the period preceding the incident? ☒ yes ☐ no just started on meds

Was a PRN used *after* the patient was placed in s/r? ☒ yes ☐ no
1345, 1445 1645 ativan po x1

What was the clinical justification for *both* chemical and mechanical restraints?
none offered

RELEASE

If seclusion used and individual went to sleep, was door unlocked and opened?
☐ yes ☐ no
If not, why? N/A

If restrained, was individual released upon falling asleep? ☐ yes ☐ no
If not, why? N/A

Was individual released within 15 minutes of exhibiting "release behaviors"? able to contract 1555
☐ yes ☒ no " pt remained calm 1½ hrs)

Who assessed patient for release? How documented? RN MD note order for med release

How was patient monitored after release? q 30 min checks - talk w/ pt to reassure safety

CONSULTATIONS AND BEHAVIOR PLANS

If patient was in s/r within the month prior to this incident, was a consultation sought?

☐ yes ☒ no

If yes, for which? ☐ Psychopharmacology ☐ Behavior

Was treatment plan modified to address identified problem behaviors? ☒ yes ☐ no

meds added

Was a behavior plan developed? ☐ yes ☐ no

Was patient involved in planning? ☐ yes ☐ no

Were changes/ new plan implemented? ☐ yes ☐ no

What behaviors resulted?

Inadequate info
Mother made AR
Precaut. ins
until 3/23/
2000
1200 hrs.

PATIENT'S COMMENTS

OTHER issues identified:

☐ appropriateness of medications

☐ informed consent/treatment over objection

☐ other

(14)

DRVD Seclusion/Restraint Usage Review Form

Client Name: Hospital: WSH Ward: A1

Date of Incident: 3/27/00 Time In: 11:45 AM Time Out: 14:00 (2:00pm)

Seclusion / (Restraint) / Both (circle one) Type of restraint 4pt. chair

Shift: ☒ 7-3 ☐ 3-11 ☐ 11-7 Weekend? ☐ yes ☒ no

Name and Title of Staff Involved:

P.A. (A2)

P.A P.A. + security

PRIOR TO INCIDENT:

Is there evidence of escalation of a behavior which resulted in an earlier intervention?

☒ yes ☐ no

if yes, did behavior begin the: ☒ previous day ☐ same day ☐ same shift

What intervention was used before the current s/r intervention?

☐ change in meds ☒ PRN meds (offered) ☐ PRN meds (forced)

☒ verbal redirection ☐ physical separation of individual from source of friction

☐ voluntary time-out ☐ forced time-out ☐ seclusion

☒ restraint (type 4 pt. restraint to bed

When did intervention begin?

☒ previous day ☐ same day ☐ same shift

Was individual on special precautions? ☐ yes ☒ no

If yes, which ones ☐ suicide ☐ homicide ☐ arson ☐ sexual predator ☐ escape

What interventions were used *prior* to initiating this s/r?

☒ PRN meds (offered) ☐ PRN meds (forced)

☒ verbal redirection ☐ physical separation of individual from source of friction

☐ voluntary time-out ☐ forced time-out ☐ seclusion

S/R INCIDENT

Documentation of reasons for S/R in chart:

- ID notes:

  Verbally threatening others, hostility, agitation, non-redirectable beh.

- MD notes:

  Threatening to hurt others on ward; very tense + angry

Does documented behavior meet definition for "emergency"? ☐ yes ☒ no

- If yes, ☐ Danger to Self ☐ Danger to Others ☐ Both

- If no, was S/R used for: ☒ punishment ☐ convenience of staff ☐ ILO treatment

S/R was abusive because:

☒ No/inadequate clinical justification for use. Cl. was able to walk to seclusion room w/out assistance or intervention from staff.

☐ Excessive force was used. If so, by whom? Nature of force? Injury? Documented that he sat calmly during application of restraints

☐ Medical or psychiatric contraindications existed. If so, describe

ASSESSMENT – HOSPITAL POLICY

Is doctor's order in file? ☒ yes ☐ no

Did doctor see patient and assess *before* initiating order? ☒ yes ☐ no

Was client monitored throughout S/R? ☒ yes ☐ no

Was monitor same gender? ☐ yes ☒ no
If not, why not?

Did doctor see patient during S/R? ☒ yes ☐ no

Does chart document checks as required by policy?

Q15 ☒ yes ☐ no VS ☒ yes ☐ no

Range of Motion ☒ yes ☐ no ☐ N/A due to limited period of S/R

was patient offered opportunity to use toilet? ☒ yes ☐ no

was patient offered water? ☒ yes ☐ no

was patient offered food? ☒ yes ☐ no ☐ N/A due to time of day

Did S/R order specify behaviors necessary for release? ☒ yes ☐ no

Was the reason for being placed in s/r clearly communicated to patient? ☒ yes ☐ no

Was criteria for discharge clearly communicated to patient? ☒ yes ☐ no

MEDS

Was patient taking prescribed psychiatric medication in the period preceding the incident? yes ☒ no

Was a PRN used *after* the patient was placed in s/r? ☒ yes ☐ no

What was the clinical justification for *both* chemical and mechanical restraints?

None

RELEASE

If seclusion used and individual went to sleep, was door unlocked and opened?

☐ yes ☐ no

If not, why?

If restrained, was individual released upon falling asleep? ☒ yes ☐ no

If not, why?

Was individual released within ~~15~~ 30 minutes of exhibiting "release behaviors"?

☐ yes ☐ no

Who assessed patient for release? How documented?

Dr. - dr I D notes by nursing staff

How was patient monitored after release?

15 min. checks for safety due to unpredictable beh.

CONSULTATIONS AND BEHAVIOR PLANS

If patient was in s/r within the month prior to this incident, was a consultation sought?

☐ yes ☐ no

If yes, for which? ☐ Psychopharmacology ☐ Behavior

Was treatment plan modified to address identified problem behaviors? ☐ yes ☐ no

Was a behavior plan developed? ☐ yes ☐ no

Was patient involved in planning? ☐ yes ☐ no

Were changes/ new plan implemented? ☐ yes ☐ no

What behaviors resulted?

PATIENT'S COMMENTS

OTHER issues identified:

☐ appropriateness of medications

☐ informed consent/treatment over objection

☐ other

APPENDIX C: SPREADSHEET SHOWING WSH'S MONTHLY USE OF SECLUSION AND RESTRAINT

3 - Fiscal Years S/R Data
(FY97/98, 98/99, 99/00)

FY 97/98	July.97	Aug.97	Sept. 97	Oct. 97	Nov. 97	Dec. 97	Jan.98	Feb.98	Mar.98	April.98	May.98	Jun.98
% of Pts. Restrained	16.5%	17.5%	17.7%	18.4%	15.7%	12.3%	15.8%	15.2%	20.0%	18.0%	15.8%	18.0%
Total Restraint Hrs.	756	1936	1244	1522	1470	972	1126	1147	1351	1279	1510	981
% of Pts.Secluded	10.5%	8.3%	8.7%	8.5%	7.1%	7.2%	6.6%	7.6%	6.4%	10.2%	7.5%	6.4%
Total Seclusion Hrs.	243	287	284	226	210	145	121	204	207	600	629	652

FY 98/99	July.98	Aug.98	Sept.98	Oct.98	Nov.98	Dec.98	Jan.99	Feb.99	Mar.99	Apr.99	May.99	Jun.99
% of Pts. Restrained	16.8%	14.1%	16%	14.2%	15.4%	15.5%	16.7%	13.7%	14.7%	10.8%	12.3%	16.3%
Total Restraint Hrs.	598	438	414	276	681	846	630	214	233	87	129	438
% of Pts.Secluded	7.6%	7.5%	7.4%	7.3%	4.3%	3.7%	5.1%	3.10%	6.3%	5.2%	5.5%	6.70%
Total Seclusion Hrs.	445	122	242	206	61	176	109	67	178	139	274	272

FY 99/00	July.99	Aug.99	Sept. 99	Oct.99	Nov. 99	Dec.99	Jan. 00	Feb.00	Mar.00	Apr.00	May.00	Jun.00
% of Pts. Restrained	13.2%	16.4%	16.0%	18.2%	22.0%	16.5%	15.4%	16.4%	22.4%	15.5%		
Total Restraint Hrs.	90	230	144	185	249	214	58	154	340	113		
% of Pts.Secluded	6%	7.3%	7.8%	5.7%	5.7%	4.2%	2.5%	4.4%	3.6%	2.7%		
Total Seclusion Hrs.	145	77	150	85	122	51	17	92	30	16		

APPENDIX D PENNSYLVANIA PROJECT OVERVIEW AND POLICY DOCUMENTS

Pennsylvania's Seclusion and Restraint Reduction Initiative

Overview

- In 1997, the Pennsylvania Department of Public Welfare's Office of Mental Heath and Substance Abuse Services (OMHSAS) announced that its nine state mental hospitals would actively pursue the immediate reduction – and ultimate elimination – of seclusion and restraint methods.
- Historically, seclusion and restraint techniques have been a part of inpatient psychiatric care since the Middle Ages and are ingrained in the culture of mental health facilities. Although used to control potentially harmful patient behavior, these techniques have long been associated with a high risk of serious patient injury and death.
- Stressing that seclusion and restraint techniques reflect treatment failure, Pennsylvania first tracked the use of these methods throughout the state mental hospital system. With data in hand, a workgroup composed of practicing hospital clinicians developed a new policy that limited seclusion and restraint use to emergency situations only.
- The policy established clear goals, strategies and monitoring systems to reduce the use of these dangerous and restrictive measures. Essential to the initiative's success were computerized data collection and analysis, organizational change strategies, medications that target aggressive behavior, staff crisis prevention and intervention training programs, risk assessment and treatment planning tools, patient debriefing methods, recovery-based treatment models, and adequate numbers of trained staff.
- Today, Pennsylvania has a seclusion and restraint policy that exceeds all national standards. The policy has enhanced physician involvement and accountability, increased patient safety, and limited use of seclusion and restraint as a last resort to situations involving imminent serious harm. The policy includes the following requirements:
    - A physician must order seclusion or restraint.
    - Orders are limited to one hour and require direct physician contact with the client within 30 minutes.
    - Patients being restrained cannot be left alone.
    - Chemical restraints are prohibited.
    - Patients and staff must be debriefed after every incident, and treatment plans must be revised.
    - Data regarding use of seclusion and restraint are made available to consumer and family organizations and government officials.
- Staff members are encouraged to pay close attention to the factors that cause or escalate aggressive and self-injurious behavior. They encourage patients to creatively resolve or avoid these factors and to develop alternative coping strategies. These strategies reinforce patient dignity and self-control and foster recovery and successful community reintegration.
- Pennsylvania's seclusion and restraint reduction initiative relies solely on existing staff and resources – without increased cost to taxpayers.

INNOVATIONS IN AMERICAN GOVERNMENT

Award Winner

Office of Mental Health and Substance Abuse Services

The Pennsylvania Department of Public Welfare

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
P.O. BOX 2675
HARRISBURG, PENNSYLVANIA 17105-2675

OFFICE OF MENTAL HEALTH &
SUBSTANCE ABUSE SERVICES

Dear Colleague:

Thank you for your interest in Pennsylvania's State Mental Hospital Seclusion and Restraint Reduction Initiative. The information you requested is enclosed.

If you have questions about any of the attached documents, please call Bonnie Hardenstine, Office of Mental Health and Substance Abuse Services (OMHSAS), Bureau of Hospital Operations (BHO), at 717-705-8159 or at E-Mail address BHardenstine@dpw.state.pa.us.

Sincerely,

Bonnie Hardenstine

Bonnie Hardenstine
CQI Coordinator

SECLUSION/RESTRAINT ISSUES

- OMHSAS (Deputy Secretary, Curie) set a clear goal of eliminating seclusion and restraint use, with strong support and follow up by Dr. Steven Karp, OMHSAS Medical Director, and the Bureau of Hospital Operations. OMHSAS has promulgated statewide policies which sharply curtail the purposes for which seclusion and restraint can be used, limit physicians' orders to 1 hour, and require physicians to visually examine patients within ½ hour of a verbal order to seclude or restrain. Guidelines were issued addressing proper and prohibited techniques and risk assessment considerations for restraint and physical management of patients, and limited seclusion and restraint use to crisis situations where the danger of physical harm to self or others is clear and present, and all other interventions have failed.
- In 1997, OMHSAS began to systematically and objectively monitor and compare incidence and duration of seclusion and restraint use per 1000 patient days each month, through the Pennsylvania Performance Measurement System (see graphs). These performance measures permit local and state managers to track each individual hospital's use over time, compare performance among facilities, establish norms against which performance can be measured. They provide hospital and state managers' quick notice of effective interventions and problems that need attention. Because this data is freely shared with advocacy groups, Planning Council and others, it provides an ongoing impetus to constructive competition among managers to move toward the desired goal, and reinforces the desired changes in culture and attitudes.
  Seclusion and restraint performance indicators are part of Pennsylvania's JCAHO approved ORYX Performance Measurement System, one of only two approved state systems in the United States. The data regarding seclusion and restraint incidence and duration are transmitted to JCAHO quarterly. Hospitals which exceed the established norms are queried by JCAHO regarding potential problems in the facility. Prolonged or excessive deviation can result in focused survey.
- Expectations for continued reduction are constantly reiterated by hospital and state level managers; good performance is reinforced; unsatisfactory performance is quickly queried and addressed.
- In 1985, each hospital averaged 4.3 incidents of seclusion per 1000 patient days. In 1994 that average dropped to 3.23. In CY 1998, the average hospital incidence fell to 1.39 seclusion incidents per 1000 patient days. In concrete terms, that means that seclusion would have been used 4 times in a 12-day period in a hospital caring for 250 patients.
- Similarly, the average number of hours in seclusion fell from 46.4 hours per 1000 patient days in each hospital in 1985 to 32.52 hours in 1994. In 1998, the average number of hours dropped to 2.5 hours per 1000 patient days.
- The same pattern holds true with restraint use and duration. In 1992/93, an average of 6 hours of restraint was used in each hospital per 1000 patient

days. This average had dropped to about 40 hours by 1994, but fell to 18 ½ hours per 1000 patient days in 1998. Restraint incidence averaged 4 per 1000 patient days in 1994, but fell to 2.9 incidents in 1998.

What other factors contribute to and permit decline in seclusion and restraint use?

1. Greatly improved anti-psychotic medications, including the new atypical anti-psychotics that specifically address aggressive/violent behavior.
2. Improved staff to patient ratios permit safer, less punitive patient management.
3. Staff are extensively trained in verbal crisis de-escalation techniques which avert physical confrontation.
4. Increased hours of active treatment, with a focus on "treatment mall" techniques that give patients more choice, more activity and more structure.
5. Standardized universal risk assessment procedures which facilitate the identification of potential behavioral risks, and target them through the treatment planning process before they precipitate crisis situations.
6. Greater attention to providing an environment which promotes dignity, comfort, privacy, choice and patient partnership in the treatment process.
7. Abolition of arbitrary ward rules developed for staff 's convenience, not patient safety.
8. Development of systematic, risk based, objective methods of determining patient freedom of movement and other privileges, which reduce the likelihood of arbitrary decision making and the confrontations that such decisions precipitate.
9. Systematic attention to identifying the specific precipitants and contexts of assaultive and self-injurious behavior, and avoiding or resolving those situations before they result in violence.
10. System wide, multi-level involvement of management staff in developing, devising and refining policy and practice has promoted healthy competition to succeed in reducing seclusion and restraint use. Frequent statewide meetings of Superintendents, Clinical Directors, Directors of Nursing, Quality Improvement Directors, Patient Advocates, Chief Pharmacists, to address issues like seclusion and restraint practice, has created a sense of ownership of this goal in every facility.
11. Decline in use has rewards for staff. Counterintuitively, seclusion and restraint decline has reduced staff injuries in frequency and severity, by eliminating most need for physical struggles with patients. Staff can feel safer and more confident of their abilities to manage SMI patients effectively, without having to use physical control measures.

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES BULLETIN

COMMONWEALTH OF PENNSYLVANIA • DEPARTMENT OF PUBLIC WELFARE

DATE OF ISSUE	EFFECTIVE DATE	NUMBER
January 29, 1999	01/15/99	OMHSAS-99-01

SUBJECT: Use of Restraints, Seclusion And Exclusion in State Mental Hospitals

BY: Charles G. Curie
Deputy Secretary for Mental Health and Substance Abuse Services

SCOPE: State Mental Hospitals

PURPOSE: To provide a standardized guideline consistent with current best practice standards for the seclusion, restraint, and exclusion in the state mental hospital system.

POLICY: Until the Pennsylvania Code, Title 55, Charter 13, is revised to reflect best practice in psychiatric treatment, State Mental Hospitals shall adopt and implement the attached procedures and practices relating to the use of seclusion, restraint and exclusion, and revise internal policy, procedure and staff training accordingly.

BACKGROUND: PA Code, Title 55, Chapter 13, regulations provide minimum guidelines for the use of seclusion, restraint and exclusion in state mental hospitals and in other non-psychiatric state institutions. These standards no longer reflect best practice in psychiatric care, nor are they as stringent as those required by the Joint Commission on Accreditation of Health Care Organizations (JCAHO). More importantly, the regulations are not consistent with the visions, goals, and objectives of the Office of Mental Health and Substance Abuse Services. Conversely, the attached standards communicate the office's belief that seclusion and restraint are neither treatment nor an acceptable substitute for treatment. In the past decade use of these techniques in Pennsylvania's State Mental Hospitals has declined substantially. Hospitals have developed strict controls and oversight of this usage, and ongoing system wide monitoring has been instituted. The attached policies and procedures will not only standardize practice across the system, but will permit OMHSAS to take another step toward the goal of eliminating the use of these techniques in the foreseeable future.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Medical Director
717-772-2351

USE OF RESTRAINTS, SECLUSION, AND EXCLUSION IN STATE MENTAL HOSPITALS

II. PHILOSOPHY OF CARE

The use of restraints, seclusion, and exclusion in a treatment setting must be directed by the values of the organization providing treatment. In order to affirm why and how restraint/seclusion/exclusion procedures are used, it is necessary to establish organizational values that guide and direct all administrative oversight and team involvement in providing treatment, while maintaining the safety of each individual patient.

Each facility/treatment setting under the scope of this document establishes and adheres to the following value statements:

Restraint/seclusion/exclusion procedures must be used as an intervention of last resort following a series of efforts by staff to promote less restrictive problem-solving by the patient and used only in emergency situations to prevent patients/residents from seriously harming themselves or others;

- Use of a restraint/seclusion/exclusion procedure is viewed as an exceptional or extreme practice for any patient;

Once a restraint/seclusion/exclusion procedure is initiated, it shall be as limited in time as possible. Staff and the patient need to work together to lessen the incidence and duration of these procedures;

- All clinical staff with a role in implementation of restraint/seclusion/exclusion procedures will be trained in their proper and safe usage;

Leaders of the hospital, leaders of clinical departments, and leaders of wards/units are held accountable at all times for the initiation, usage, and termination of restraint/seclusion/exclusion procedures. This accountability is demonstrated as a component of the hospital's Performance Improvement efforts and staff competency evaluations;

The patient and family, as appropriate, are recognized members of the treatment team;

- The Client Representative or Patient Advocate is recognized as a spokesperson for the patient and shall be involved in care and treatment, if the patient so desires (within the parameters of current law/regulation);

The treatment plan shall address specific interventions to be used to avoid restraint/seclusion/exclusion procedures and shall address patient strengths and cultural competencies;

- All decisions to initiate restraint/seclusion/exclusion procedures shall be based on assessment of the patient and the rationale to proceed;

  Patient involvement in a post-procedure debriefing and discussion is essential to determine how future situations may be de-escalated by employing alternative problem-solving measures, and how restraint/seclusion/exclusion procedures can be avoided;

- Patient dignity shall be maintained to the extent possible during these procedures;

  Restraint/seclusion/exclusion procedures shall not be initiated or maintained as a substitute for treatment, as punishment, or for the convenience of staff;

- Restraint and seclusion are safety interventions, not therapeutic techniques, but as with all mental health interventions, shall be implemented in a careful and therapeutic manner;

- In administering restraints and seclusion, as well as in attempting to prevent its use and the necessity for subsequent/recurrent use, staff shall recognize and use the strengths of the patient, and remain sensitive to issues of cultural competence; and

- The commitment status of the patient requiring seclusion/restraint/exclusion shall be reviewed prior to initiating any of these procedures.
  1. Patients who are involuntarily committed may be placed in seclusion, restraint, or exclusion if indicated, but only when less restrictive measures and techniques have proven ineffective.
  2. If a patient in voluntary treatment (Legal Section 201) requires seclusion, restraint or exclusion, it is possible to utilize such measures if this has been agreed upon in the initial evaluation signed by the patient as part of the voluntary commitment procedure. However, if the patient retracts or denies this agreement concerning possible restrictions and restraints, and refuses their use, an involuntary commitment must be obtained as soon as possible under the criteria, standards, and procedures of Legal Section 302 or 304C if seclusion, restraint or exclusion are ordered.
  3. Residents of the State Restoration Center are not subject to the provision of seclusion, restraints or exclusion. Should a resident require the use of one of these modalities for psychiatric reasons, commitment to a psychiatric treatment facility shall be initiated.

The specific methods and ways to implement and monitor these values are detailed in the following sections.

SECLUSION

DEFINITION: A brief, time limited adjunct modality involving the placement of a patient into a safe, well ventilated, furniture-free, visually observable locked room for the purpose of assisting the individual to regain emotional and physical control over his/her dangerous, destructive behaviors.

NOTE: Seclusion is **not** a modality utilized in the State Restoration Center.

INDICATIONS: Prior to the use of seclusion, the following criteria must be met:

a. All less restrictive options/interventions, including changes in pharmacological interventions, have been considered and attempted and have failed to diminish the patient's immediate danger to self and/or others. Documentation of all such efforts shall be entered into the patient's medical record, in addition to rationale and justification of the need for seclusion;

b. Unless clinically contraindicated, prior to the use of seclusion the patient shall be given a choice of treatment options that may assist with limiting the environmental stimuli and their consequent effects on the patient's emotional status. The reason/justification for seclusion shall be communicated clearly to the patient. Treatment expectations and the outcomes which should occur within brief, time limited intervals shall be carefully explained; and

c. Seclusion is an adjunct to treatment with defined clinical parameters of expected care and, therefore, shall never be used in a punitive or otherwise non-therapeutic manner.

CONTRAINDICATIONS: Seclusion shall not be used for patients who exhibit suicidal or self-injurious behaviors or who have any known medical condition which precludes the safe application of this modality (such situations shall be determined by the attending/on-call physician on a case-by-case basis).

TREATMENT EXPECTATIONS:

For seclusion to be an efficacious adjunct to treatment, the following procedures shall be in place:

a. Each patient shall be made aware of the specific behaviors that necessitated the use of seclusion and those behaviors and mental status components which will terminate seclusion;

b. Individual treatment plans shall have goals and interventions established to eliminate the need for seclusion;

c. Seclusion shall be used only with a physician's order. In emergency situations, a registered nurse may initiate the use of seclusion for the protection of the patient and/or others. The physician on duty/on-call shall be contacted immediately, and a verbal order may be obtained. The physician's order shall not exceed one (1) hour. Orders shall specify "up to" one (1) hour, rather than a predetermined amount of time. The physician involved shall see the patient within thirty (30) minutes of the initiation of seclusion (barring extenuating circumstances), and then shall write/countersign the order for the seclusion and document his/her assessment of the patient in the medical record. Specific behavioral criteria written by the physician shall specify when the seclusion may be discontinued, to insure minimum usage. When a physician's order has expired, the patient must be seen by a physician and his/her assessment of the patient documented before seclusion can be reordered;

d. Patients in seclusion shall be monitored/checked at routine intervals not to exceed fifteen (15) minutes. Monitoring may occur at more frequent intervals, depending upon an individual patient's presenting behavior;

e. Patients are to be removed immediately from the seclusion room once the danger to self or others is no longer imminent;

f. During the seclusion process, each patient's dignity and need for physical care shall be carefully monitored and addressed. Each patient's safety is of paramount concern and, as such; potentially dangerous clothing and objects shall be removed from the patient and the seclusion area. This, however, does not prohibit the use of appropriate non-dangerous attire or such things as may be therapeutically indicated (i.e., soft inanimate objects, magazines, etc.);

g. Patient physical needs shall be met promptly. Opportunity for personal care, including fluids, bathroom use, exercise, meals and hygiene, shall be provided and documented throughout each seclusion incident; and

h. When the patient is released from seclusion a mental health professional who is a member of the treatment team shall meet with the patient for the purpose of:

1. Assisting the patient to develop an understanding of the precipitants which may have evoked the behaviors necessitating the use of seclusion;

2. Assisting the patient to develop appropriate coping mechanisms or alternate behaviors that could be effectively utilized should similar situations/emotions/thoughts present themselves again;

3. Developing and documenting a specific plan of interventions for inclusion in the Comprehensive Individualized Treatment Plan, with the intent to avert future need for seclusion.

i. The team member shall document the patient interview process in the patient's medical record.

CONTINUOUS PERFORMANCE IMPROVEMENT MONITORING:

a. The leadership staff of each state mental hospital shall maintain a performance improvement program designed to continuously review, monitor, and analyze the use of seclusion and issues related to this process. Ongoing efforts to reduce utilization of seclusion shall be employed.

b. The facility Chief Executive Officer of each state mental hospital is responsible for assuring that ongoing documentation and monitoring of patients placed in seclusion is maintained. Monitoring shall consist of reviewing the necessity for use or continuation of seclusion based upon documentation of unsuccessful, less restrictive alternatives, and appropriate rationale and justification. Patient "debriefing", health teaching, clinical response to seclusion, treatment plan revisions, and incidents where the physician involved does not see the patient within thirty (30) minutes of the initiation of seclusion shall also be monitored.

STAFF TRAINING:

All staff training regarding the use of seclusion as an adjunct to treatment shall embody the philosophy that seclusion results only after all less restrictive interventions have been appropriately considered/implemented and the patient continues to present a clear and present danger to self and/or others.

a. Training of staff shall focus upon identifying the earliest precipitant of aggression for patients with a known, suspected, or present history of aggressiveness, and on developing treatment strategies to prevent exacerbation or escalation of these behaviors. Patient involvement in the identification of precipitants is paramount.

b. Training shall encompass the primary importance of patient safety, at all times, during the seclusion process. This shall include the time preceding the placement of a patient into seclusion as well as the time spent in the seclusion area.

c. Training shall be provided to all treatment staff during employment orientation and on an annual basis.

d. Training shall also include the nature and identification of the possible negative psychological effects seclusion may have upon some individuals, and offer positive therapeutic strategies to combat such effects.

RESTRAINT

DEFINITION: A restraint is any manual method or physical or mechanical device used for the purpose of restricting freedom of movement. Restraints do not include general protective security measures such as locked wards or security measures ordered by a court. Restraints may be used for the following purposes:

(1) To control acute or episodic aggressive behavior which presents an immediate danger to self and/or others.

(2) To provide medical care or treatment or to prevent the worsening of a physical condition when a patient is unable to comprehend or cooperate.

Examples include preventing a confused or thought-disordered patient from removing a feeding tube, walking on a fractured foot, pulling out sutures, etc.

EXCLUDED FROM THE DEFINITION OF RESTRAINT ARE:

(1) Adaptive supports used to permit a patient to achieve maximum normative bodily functioning, or to promote normative body positioning, such as mechanisms used to control involuntary movements or to compensate for paralysis, and

(2) Protective devices used to prevent safety incidents not related to cognitive impairment, such as bedrails/halfrails, removable safety belts, protective helmets, or devices to prevent a cognitively intact patient from rolling out of bed.

NOTE: The State Restoration Center shall follow all current State and Federal regulations relating to use of adaptive supports and protective devices.

CONTRAINDICATIONS: Restraints shall not be utilized for patients with any known medical condition which precludes the safe application of this modality (such situations shall be determined by the attending/on-call physician on a case-by-case basis).

INDICATIONS: Restraint, for any reason, may only be used when less restrictive treatment options/interventions, including changes in pharmacological interventions, have been formulated, attempted, and are documented to have failed. All members of the treatment planning team shall be involved in preventing and reducing the need for restraints by treating the patient and resolving the problem which necessitates restraint.

a. Prior to the use of restraint for aggressive behavior which presents an immediate danger to self and/or others, the patient (unless clinically contraindicated) will be given a choice of treatment options to enable him/her to regain self-control over the injurious behavior. The reason for restraint shall be communicated clearly to the patient. Behavioral expectations shall be clearly explained as conditions for release from restraint. Restraint shall never be used as substitute for treatment or in a punitive or otherwise non-therapeutic manner.

b. Prior to the use of restraint for medical reasons, the cause for which the restraint is being considered shall be thoroughly assessed and documented by the physician and treatment team. Restraints shall only be used for a strictly defined period of time and for a clearly defined purpose. Alternative interventions shall be added to the treatment plan and implemented to reduce the need for medical restraint. Restraint alternatives include (but are not limited to): physical therapy, ambulatory assistive devices, alarms, reclining chairs without trays, positioning devices, non-slip cushions, safety belts (which are removable by the patient), non-slip shoes, etc.

TREATMENT EXPECTATIONS:

a. Individual treatment plans shall have goals and interventions written to eliminate the need for restraints. In instances of aggressiveness, plans shall also include behavioral indicators of impending behavior and positive, constructive crisis interventions;

b. Restraints shall include wrist and ankle restraints, mitts, vests, body net, pelvic supports, gerichairs with trays, ambulatory restraints (preventive aggression devices), helmets, waist and pelvic restraints, and muffs. Only approved devices may be used according to manufacturer's instructions and for the purpose intended;

c. Restraints are prescription devices and shall be used only with a physician's order. In emergency situations, a registered nurse may initiate the use of restraints for the protection of the patient and/or others. The physician on duty/on-call shall be contacted

immediately and a verbal order may be obtained. The physician's order shall not exceed one (1) hour. Orders shall specify "up to" one (1) hour, rather than a pre-determined amount of time. The physician involved shall see the patient within thirty (30) minutes of the initiation of the restraints (barring extenuating circumstances), and then shall write/countersign the order for the restraints and document his/her assessment of the patient in the medical record. Specific behavioral criteria written by the physician shall specify when the restraints may be discontinued, to insure minimum usage. When a physician's order has expired, the patient must be seen by a physician and his/her assessment of the patient documented before restraints can be reordered;

d. Patients in restraints shall be placed on constant 1:1 observation (at arm's length), and this action is to be documented by attending staff;

e. Physical needs shall be met promptly. Opportunity for personal care, including fluids, bathroom use, exercise, meals and hygiene, shall be provided and documented throughout each restraint incident.

f. When the patient is released from restraints used to control aggressive or self-injurious behaviors, a mental health professional member of the treatment team shall meet with the patient for the purpose of:

1. Assisting the patient to develop an understanding of the precipitants which may have evoked the behaviors necessitating the use of restraint;

2. Assisting the patient to develop appropriate coping mechanisms or alternate behaviors that could be effectively utilized should similar situations/emotions/thoughts present themselves again;

3. Developing and documenting a specific plan of interventions for inclusion in the Comprehensive Individualized Treatment Plan, with the intent to avert future need for restraint.

4. The team member shall document the patient interview process in the patient's medical record.

CONTINUOUS PERFORMANCE IMPROVEMENT MONITORING:

a. The leadership staff of each state mental hospital shall maintain a performance improvement program designed to continuously review, monitor, and analyze the use of restraint. Ongoing efforts to reduce utilization of restraint shall be employed.

b. The facility Chief Executive Officer of each state mental hospital is responsible for assuring that ongoing documentation and monitoring of patients placed in restraints is maintained. Monitoring shall consist of reviewing the necessity for use or continuation of restraint based upon documentation of unsuccessful, less restrictive alternatives, and appropriate rationale and justification. Appropriate patient "debriefing," health teaching, clinical response to restraint, subsequent revised plan of care, and incidents where the physician involved does not see the patient within thirty (30) minutes of the initiation of restraints shall also be monitored.

STAFF TRAINING:

All staff training regarding the use of restraint as an adjunct to treatment, shall embody the philosophy that restraint results only after all less restrictive interventions have been appropriately considered/implemented and the patient continues to present a clear and present danger to self and/or others.

a. Training of staff shall focus upon identifying the earliest precipitant of aggression for patients with a known, suspected, or present history of aggressiveness, and on developing treatment strategies to prevent exacerbation or escalation of these behaviors. Patient involvement in the identification of precipitants is paramount.

b. Training shall encompass the primary importance of patient safety, at all times, during the restraint process. This shall include the time preceding the placement of a patient into restraint as well as the time spent in the restraint.

c. Training shall be provided to all treatment staff during employment orientation and on an annual basis.

d. Training shall also include the nature and identification of the possible negative psychological effects restraint may have upon some individuals, and offer positive therapeutic strategies to combat such effects.

BEHAVIORAL RESTRICTIONS

DEFINITION: Behavioral restrictions are therapeutic interventions which involve either temporary and time limited removal of a patient's usual privileges and/or restrictions on participation in specific activities. Behavioral restrictions are enacted by the treatment team to prevent specific behaviors that are assessed to have a reasonable probability of posing a significant danger to self and/or others.

INDICATIONS/TREATMENT EXPECTATIONS:

1. In an emergency situation, any treatment team member may impose behavioral restriction from, or within, a patient activity, until review by the treatment team;

2. A physician's order must be written for any restriction. This order must be reviewed and renewed at least once every twenty-four (24) hours, authorizing the use of the specific restriction in response to the behavior targeted for prevention. The physician shall document the following information in a progress note accompanying the order:

   a. The behavior to be prevented;
   b. The restriction to be imposed, and the duration of the restriction;
   c. The condition(s) under which the restriction will be lifted;
   d. The clinical rationale for the restriction's expected effectiveness (and its actual effectiveness in subsequent review notes);
   e. Any treatment to be used in combination/conjunction with the restriction, designed to reduce the likelihood of the behavior necessitating the restriction.

3. The restriction must be documented in the patient's treatment plan as an intervention/approach.

4. The restriction may not impede the patient's exercise of rights established by the Bill of Rights (Section 5100.53-54 of Title 55, Chapter 5100 Regulations), or deny access to adequate sustenance, clothing, shelter, or non-criminal communication with others, nor may it remove civil rights which have not been limited by the courts.

5. The restriction must be logically and therapeutically related to the behavior it is intended to prevent.

6. The restriction may not be imposed arbitrarily, or as a punishment, or involve actions which are likely to cause physical pain or injury or psychological harm to the patient.

CONTINUOUS PERFORMANCE IMPROVEMENT MONITORING:

a. The leadership staff of each state mental hospital shall maintain a performance improvement program designed to continuously review, monitor, and analyze the use of behavioral restrictions. Ongoing efforts to reduce utilization of behavioral restrictions shall be employed.

b. The facility Chief Executive Officer of each state mental hospital is responsible for assuring that ongoing documentation and monitoring of patients under behavioral restrictions is maintained. Monitoring shall consist of reviewing the necessity for use or continuation of behavioral restrictions based upon documentation of less restrictive alternatives, and appropriate rationale and justification. Appropriate patient health teaching, clinical response to behavioral restrictions, and treatment plan revisions shall also be monitored.

STAFF TRAINING:

All staff training regarding the use of behavioral restrictions as an adjunct to treatment, shall embody the philosophy that behavioral restrictions result only after other less restrictive interventions have been appropriately considered/implemented.

a. Training of staff shall focus upon identifying the precedents to behaviors which warrant the use of behavioral restrictions and on developing treatment strategies to avert these behaviors. Patient involvement in the treatment approach is paramount.

b. Training shall encompass the primary importance of patient rights and safety, at all times during the imposition of behavioral restrictions.

c. Training shall be provided to all treatment staff during employment orientation and on an annual basis.

CHEMICAL RESTRAINTS

DEFINITION: Chemical restraint shall mean the use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior by a patient. Chemical restraints shall be further defined as those agents which result in a significant lowering of the level of consciousness, in which the patient would be semi-stuporous with significantly decreased ability to attend to his/her personal needs.

Drugs administered on a regular basis, as part of the individualized treatment plan, and for the purposes of treating the symptoms of mental, emotional or behavioral disorders, and for assisting the patient in gaining progressive self-control over his/her impulses, are not considered chemical restraints.

INDICATIONS: It shall be the policy of the Department of Public Welfare and the Office of Mental Health and Substance Abuse Services that chemical restraints are not utilized at any state mental hospital or the Restoration Center.

CONTINUOUS PERFORMANCE IMPROVEMENT MONITORING:

The facility Chief Executive Officer of each state mental hospital and the Restoration Center, in conjunction with the Medical Staff, is responsible for assuring that ongoing drug utilization monitoring of patients/residents is maintained to ensure that chemical restraints are not prescribed. Leadership staff (including Nursing, Pharmacy, and Quality Improvement) and the facility Pharmacy & Therapeutics Committee shall maintain compliance with the provisions of this policy through the institution of performance improvement programs designed to continuously review, monitor, and analyze drug utilization.

EXCLUSION

DEFINITION: The therapeutic removal of a patient from his/her immediate environment and the restriction of this individual to an unlocked (quiet) room for a brief, time limited period for the purpose of assisting the individual to regain emotional control. Exclusion involves the patient's cooperation in leaving the immediate environment and in remaining in another, specified area (e.g., unlocked seclusion room) with the door open and unlocked for a specified period of time. Each facility shall designate rooms/areas to be utilized for exclusion.

NOTES:

a. A patient's request to spend time in a private, unlocked room is not considered exclusion and should be granted where feasible and not clinically or therapeutically contraindicated;

b. Quarantine or other preventive health measures are not considered exclusion; and

c. Exclusion is not a modality utilized in the State Restoration Center.

INDICATIONS: Prior to the use of exclusion, the following criteria must be met:

a. All lesser restrictive treatment options/interventions, including the use of alternative pharmaceutical interventions have been considered and attempted and have failed to diminish the patient's escalating behavior. Documentation of all such efforts shall be entered into the patient's medical record as well as the necessary rationale and justification of the exclusion need;

b. Unless clinically contraindicated, prior to the use of exclusion the patient shall be given a choice of treatment options that may assist with limiting the environmental stimuli and their consequent effects on the patient's emotional status. The reason/justification for exclusion shall be communicated clearly to the patient. Treatment expectations shall be carefully explained, including the outcomes which should occur within brief, time limited intervals; and

c. Exclusion is an adjunct to treatment with defined clinical parameters of expected care and, therefore, shall <u>never</u> be used in a punitive or otherwise non-therapeutic manner.

CONTRAINDICATIONS: Exclusion shall <u>not</u> be utilized for patients who exhibit suicidal or self-injurious behaviors or who have a known seizure disorder or

any other medical condition which precludes the safe application of this modality (such situations shall be determined by the attending/on-call physician on a case-by-case basis).

TREATMENT EXPECTATIONS:

For exclusion to be an efficacious adjunct to treatment, the following procedures shall be in followed:

a. Each patient shall be made aware of the specific behaviors that necessitated the use of exclusion and those behaviors and mental status components which will terminate the exclusion;

b. Individual treatment plans shall have goals and interventions established to eliminate the need for exclusion;

c. Exclusion shall be used only with a physician's order. In emergency situations, a registered nurse may initiate the use of exclusion. Immediately the physician on duty/on-call shall be contacted and a verbal order may be obtained. The physician's order shall not exceed one (1) hour. Orders shall specify "up to" one (1) hour, rather than a predetermined amount of time. The physician involved shall see the patient within thirty (30) minutes of the initiation of exclusion (barring extenuating circumstances) and then shall write/countersign the order for the exclusion, and document his/her assessment of the patient in the medical record. Specific behavioral criteria written by the physician shall specify when the exclusion may be discontinued, to insure minimum usage. When a physician's order has expired, the patient must be seen by a physician and his/her assessment of the patient documented before exclusion can be reordered;

d. Patients in exclusion shall be monitored/checked at routine intervals not to exceed fifteen (15) minutes;

e. Exclusion shall not affect the rights of an individual to basic sustenance, clothing, or communication with appropriate or responsible persons (i.e., family, attorneys, physicians, patient advocates, or clergy); however, any person wishing to visit the patient in exclusion must gain authorization from the attending/on-call physician;

f. Patient physical needs shall be met promptly. Opportunity for personal care, including fluids, bathroom use, exercise, meals, and hygiene shall be provided and documented throughout each exclusion incident; and

g. When the patient is released from exclusion a mental health professional member of the treatment team shall meet with the patient for the purpose of:

1 Assisting the patient to develop an understanding of the precipitants which may have evoked the behaviors necessitating the use of exclusion;

2. Assisting the patient to develop appropriate coping mechanisms or alternate behaviors that could be effectively utilized should similar situations, emotions, or thoughts present themselves again;

3. Developing and documenting a specific plan of additional interventions as a part of the Comprehensive Individualized Treatment Plan, with the intent to avert future need for exclusion; and

4. The team member shall enter documentation of the interview process into the patient's medical record.

CONTINUOUS PERFORMANCE IMPROVEMENT MONITORING:

a. The leadership staff of each state mental hospital shall maintain a performance improvement program designed to continuously review, monitor, and analyze the use of exclusion. Ongoing efforts to reduce utilization of exclusion shall be employed.

b. The facility Chief Executive Officer of each state mental hospital is responsible for assuring that ongoing documentation and monitoring of patients placed in exclusion is maintained. Monitoring shall consist of reviewing the necessity for use or continuation of exclusion based upon documentation of failed lesser restrictive alternatives, appropriate rationale, and justification. Appropriate patient "debriefing", health teaching, clinical response to exclusion, subsequent revised plan of care, and incidents where the physician involved does not see the patient within thirty (30) minutes of the initiation of exclusion shall also be monitored.

STAFF TRAINING:

All staff training regarding the use of exclusion as an adjunct to treatment, shall embody the philosophy that exclusion results only after all less restrictive interventions have been appropriately considered/implemented.

a. Training of staff shall focus upon identifying the earliest precipitant for patients with a known, suspected, or present history of unacceptable behaviors and developing treatment strategies to prevent exacerbation of these behaviors. Patient involvement in the identification of precipitants is paramount.

b. Training shall encompass the primary importance of patient safety at all times during the exclusion process. This shall include the time preceding the placement of a patient into exclusion as well as the time spent in the exclusion area.

c. Training shall be provided to all treatment staff upon employment orientation and on an annual basis.

d. Training shall also include the nature and identification of the possible negative psychological effects exclusion may have upon some individuals and offer positive therapeutic strategies to combat such effects.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

FEB 03 1999

SUBJECT: Guidelines for the Use of Physical Management and Mechanical Restraint Techniques

TO: CEOs, State Mental Health Facilities and Assistant Superintendents for Clinical Services

FROM: Steven Karp, D.O. *SKarp*
Medical Director

In recent months national attention has been directed toward the techniques used to restrain and physically contain persons hospitalized for psychiatric treatment, living in residential treatment settings, residing in nursing homes and even those who are incarcerated, during crisis in which their behavior poses a danger of harm to self or others. Following press reports of the death of persons subject to physical or mechanical restraint, the National Alliance for the Mentally Ill called upon the federal government to investigate and provide oversight into patient deaths in restraint. Pennsylvania Protection and Advocacy has requested we officially ban restraint practices which may have adverse medical consequences, and JCAHO had published a summary and analysis of sentinel event restraint death root causes, with recommendations for safer practice.

We have subsequently affirmed that each hospital's use of physical and mechanical restraint application techniques is based on a variety of private sector training and certification programs. These programs usually include verbal and nonverbal crisis de-escalation techniques, self-defense and physical containment strategies to promote safe physical management of the patient. Training in these certified programs is required at the time of employment, usually for all staff in patient contact assignments, and annually for all direct care staff engaged in actual physical management of patients (i.e. nursing). Internal hospital policies were subsequently developed to require use of the techniques taught in these programs.

Safe physical management technique training was originally mandated for all direct care staff in state mental hospitals over 15 years ago, using a copyrighted training program provided by OMH through a private vendor. During subsequent years, some hospitals have updated the curricula, or contracted with new vendors for this service. Consequently, the systems in place across the state are no longer consistent. Although none of these systems appears to teach techniques that are now known to increase risk of harm during the physical management or restraint of patients, they may not explicitly prohibit the methods

and techniques that are more likely to incur a risk to patient safety nor describe the reasons for such risk.

The purpose of this memorandum is to apprise all Superintendents and Assistance Superintendents for Clinical Services of the following risk factors and guidelines for the prevention of restraint deaths. They shall ensure that hospital policy and direct care staff training reflect these guidelines.

A. Factors contributing to risk of asphyxia during physical management and restraint:

- Cocaine induced excited delirium (impaired thinking, disorientation, visual hallucinations, etc.) may increase the heart rate to a critical level when the patient is being restrained or is confined to restraints.
- Drug or alcohol intoxication reduce respiratory drive, diminishing the individual's realization that suffocation is occurring.
- The patient who engages in extreme violent activity and struggles may be more vulnerable to subsequent respiratory failure during physical intervention and restraint.
- Sudden unresponsiveness or limpness during or immediately after a struggle may indicate cardiopulmonary events that warrant immediate medical attention.
- Pre-existing risk factors combined with body position can compound the risk of sudden death, particularly following a struggle. These risk factors include:
    - Obesity
    - Alcohol and drug use
    - An enlarged heart (stress and low blood oxygen enhance the susceptibility to cardiac arrest)
    - Smoking
    - Deformities that preclude proper restraint positioning
    - Emphysema, bronchitis, asthma, COPD and other respiratory conditions enhance risk, especially if the patient is placed face down.
    - Seizure disorder
    - Involuntary movement disorder, i.e. Huntingtons, spastic CP, dysphagia
    -

B. Procedural factors that increase risk during the restraint process:

- All of the above pre-existing risk factors are exacerbated when the patient is placed in a face down position and/or when "hands are held behind the back" holds or restraints are employed.
- When the patient is held or restrained in a face down (prone) position, lungs are compressed and breathing may become labored. The more

pressure that is applied to the person's torso, the more compression is increased.

- Restraint in a supine (face up) position may predispose the patient to aspiration.
  Inadequate numbers of staff to safely manage mechanical restraint application may increase the likelihood that staff will place their body weight across the patient's back, or use other unsafe practices which enhance the danger of patient injury.
  Failure to search the patient for contraband when placed in mechanical restraints can result in fire from attempted use of smoking materials, or other self-harm.
- Placing a pillow, blanket or other item under or over the patient's face as part of a restraint or holding process, especially when the patient is in a prone position, may result in suffocation.
- Use of high neck vests are blamed for strangulation deaths in geriatric patients, as are use of unprotected split side bed rails.
- Incorrect application of a mechanical restraint device enhances strangulation potential.
- Techniques which pull the patient's or employee's arms across the neck contribute to risk of asphyxiation.
- Leaving a patient in mechanical restraints without continuous staff observation precluded timely corrective action in response to physical distress.

C. Guidelines for safe physical management and restraint.

Effective immediately, the following practices shall be adopted and incorporated into staff training curricula:

1. No fewer than 3 staff persons shall be present to apply mechanical restraints. If insufficient staff are available to safely control and restrain a patient in a psychiatric crisis, staff should remove others from harm's way and get help before attempting physical management or restraint.
2. At no time is pressure to be placed upon the patient's back while the patient is in the prone position in a floor control situation. Patient arms, shoulders, and legs are to be immobilized. Staff body weight is not to be applied to the torso or above the upper thighs.
3. Patients in restraints must be placed under a physician's order for constant staff observation for the duration of the restraint.
4. Patients placed in seclusion or restraint must always be promptly searched for contraband.
5. High neck vests or waist restraints are not to be used for body positioning in geriatric or long term care settings, nor is any patient to be restrained to a bed with unprotected split side rails.
6. Never place a towel, bag, blanket or other cover over a patient's face during the physical management process or during use of mechanical

restraints. Staff shall maintain observation of the patient's head in order to ensure that the airway is kept open.

7. If a patient is placed under floor control in a prone position for the purpose of administering an injection or application of mechanical restraint, the patient shall be rolled/turned to the supine (face up) position as soon as the procedure is completed, unless the risk or act of vomiting is present.
8. When restraining patients in a supine position, ensure that the head is free to rotate. The head of the bed should be elevated to minimize the risk of aspiration, unless clinically contraindicated.
9. Physicians ordering for restraint shall assess, consider and document the patient's pre-existing physical condition when ordering the body position, number and manner of mechanical restraints. This includes occasions when verbal orders are issued.

Deviation from the above guidelines for clinical reasons in individual cases must be documented by the physician ordering the restraint and reviewed by the Assistant Superintendent for Clinical Services

In the coming months, I will be reviewing available physical management technologies and training programs with the Assistant Superintendents for Clinical Services and the Statewide Risk Management Committee in order to select a statewide training curriculum. Until then, please be sure that your staff are made aware of the aforementioned risk factors and policy guidelines.

cc: Mr. Curie
Mr. Kopchick
Ms. Hardenstine

OMHSAS POLICY

RESTRICTED USE

- Seclusion/restraint use permitted only as a safety measure when all else has failed and the patient presents imminent danger of physical harm to self or others.

CONDITIONS NEEDED TO SIGNIFICANTLY ALTER SECLUSION AND RESTRAINT USE

- Strong leadership commitment: State and local.
- Adequate staff/pt. ratio (2 to 1).
- Staff training in verbal crisis de-escalation techniques and safe physical management.
- Involvement and commitment by all levels of staff.
- Abundance of active, meaningful treatment options, which foster choice and consumer involvement.
- Systematic consumer risk assessment and risk-based treatment planning, which address the precipitants of violence.

- Aggressive use of 2nd generation antipsychotic medications.
- An environment of care that fosters patient dignity and choice and eliminates rules made for staff convenience.
- Open communication about goal of elimination and hospital progress toward that goal.

JCAHO STANDARDS	*OMHSAS POLICY*
PATIENTS IN RESTRAINTS MUST BE MONITORED EVERY 15 MINUTES.	PATIENTS IN RESTRAINT ARE KEPT UNDER CONSTANT OBSERVATION WITH STATUS DOCUMENTED EVERY 15 MINUTES.
ANY LICENCED, INDEPENDENT PRACTIONER MAY ORDER RESTRAINT OR SECLUSION WITH LEGAL AND ORGANIZATIONAL AUTHORIZATION.	ONLY A PHYSICIAN MAY ORDER SECLUSION OR RESTRAINT.
ANY AUTHORIZED PERSON MAY INITIATE SECLUSION AND RESTRAINT FOR UP TO ONE HOUR IN AN EMERGENCY. A LICENSED, AUTHORIZED PRACTIONER MUST BE CALLED TO PROVIDE AUTHORIZATION FOR CONTINUED USE WITHIN ONE HOUR OF ITS INITIATION.	REGISTERED NURSES MAY SECLUDE OR RESTRAIN A PATIENT IN AN EMERGENCY, BUT A VERBAL PHYSICANS'S ORDER MUST BE IMMEDIATELY OBTAINED, AND THE PHYSICIAN MUST PERSONALLY ASSESS THE PATIENT WITHIN 30 MINUTES.

CONDITIONS NEEDED TO SIGNIFICANTLY ALTER SECLUSION AND RESTRAINT USE

- Strong leadership commitment: State and local.
- Adequate staff/pt. ratio (2 to 1).
- Staff training in verbal crisis de-escalation techniques and safe physical management.
- Involvement and commitment by all levels of staff.
- Abundance of active, meaningful treatment options, which foster choice and consumer involvement.
- Systematic consumer risk assessment and risk-based treatment planning, which address the precipitants of violence.

- Aggressive use of 2nd generation antipsychotic medications.
- An environment of care that fosters patient dignity and choice and eliminates rules made for staff convenience.
- Open communication about goal of elimination and hospital progress toward that goal.

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COMMONWEALTH of VIRGINIA

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May 31, 2001

Susan Ferguson, Esq., Director
Department of Rights of Virginians with Disabilities
Ninth Street Office Building
202 North 9th Street, 9th Floor
Richmond, Virginia 23219

Dear Ms. Ferguson:

Thank you for recently forwarding to my attention a copy of the Department for Rights of Virginians with Disabilities Report on the Use of Seclusion and Restraint at Western State Hospital (WSH).

The Department shares with DRVD the principle that seclusion or restraint should be interventions of last resort. In support of this philosophy, the Department has implemented a number of initiatives over the past two years which we feel have been instrumental in reducing seclusion or restraint across facilities. A clear message has been given by the administration that use of seclusion or restraint must decrease. There have been increasing reviews of use of these interventions, and Behavior Management Committees have reduced thresholds for case reviews. In addition, Behavioral Consultation Teams have been established in many of the facilities including Western State Hospital (WSH), and there has been increased observation of patients in seclusion as well as a focus on the quality of active treatment of clients. More recently, a new Departmental Instruction has been implemented to guide all facilities in the acceptable use of seclusion or restraint. These initiatives appear to have been helpful in reducing use of seclusion or restraint across our facilities system.

More specifically related to WSH, a 73% decrease in seclusion or restraint hours has been demonstrated between FY 1998 through FY 2000. Of course, we continue to look for vehicles for improvement. Therefore, WSH will be implementing a new monitoring system regarding the use of seclusion and restraint by July 1, 2001. All physicians and nursing staff will be trained in the use of this instrument and expectations regarding monitoring. The specific measures will provide the information and feedback

mechanism to assure that WSH is utilizing seclusion or restraint interventions only as a last resort. Every use of emergency seclusion or restraint will be reviewed against the instrument we have attached. This document will also assist WSH in being responsive to the variety of recommendations you have made relative to the use of seclusion or restraint. The enclosed response to your recommendations delineates more completely how the attached instrument addresses your concerns.

Your letter states that DRVD plans to begin follow-up on seclusion and restraint use at WSH in August-September, 2001. I would like to point out that the Department of Justice (DOJ) is anticipated to be conducting its WSH consultation visit in September. Facility staff are actively working with DMHMRSAS consultants to prepare for that visit; and part of the facility's effort is compliance with the DOJ document request, which is considerable. Given the time and resource demands placed upon WSH staff in preparation for the DOJ visit, I respectfully request that any DRVD follow-up be scheduled after September 2001.

Thank you again for allowing us an opportunity to respond to your report and for working with the Department to assure the most appropriate interventions are used to address client needs and protections.

Sincerely,

Richard E. Kellogg

Richard E. Kellogg

REK/ls

Enclosures

RESPONSE TO DRVD REPORT ON THE USE OF SECLUSION AND RESTRAINT - WESTERN STATE HOSPITAL (WSH)
DRVD Report dated April 23, 2001

As referenced in the cover memorandum, for the past two years, WSH has worked diligently to change clinical practices regarding use of seclusion and restraint. Recently, in order to make further improvements, WSH revised its monitoring system for seclusion and restraint. A new monitoring tool, which is attached, will be implemented by July 1, 2001. This tool will help ensure that the issues raised in your recommendations are addressed appropriately. The itemized responses below indicate the sections of the WSH monitoring tool that relate to each of your recommendations.

I. Recommendation: WSH must attempt less restrictive interventions before resorting to the use of seclusion and restraint methods.

In the attached monitoring document, items # 1, 2, and 3 address this recommendation:

1. Was behavior evidencing imminent likelihood of harm documented?
2. Were at least three less restrictive interventions documented?
3. Were dangerous behaviors indicating a lack of response to lesser restrictive measures & continued behavioral emergency documented?

II. Recommendation: When WSH utilizes seclusion and restraint methods, it must use the least restrictive method.

In the attached monitoring document, item # 5 addresses this recommendation:

5. Was a RN/MD assessment of current patient mental status, patient behavior, reasons for S&R and other less restrictive alternatives, including less restrictive seclusion or restraint procedures, which were considered documented?

III. Recommendation: WSH must only use seclusion and restraint methods when they are clearly warranted.

In the attached monitoring document, items # 1, 2, 3, and 5 address this recommendation:

1. Was behavior evidencing imminent likelihood of harm documented?
2. Were at least three less restrictive interventions documented?
3. Were dangerous behaviors indicating a lack of response to less restrictive measures & continued behavioral emergency documented?

(Recommendation III, Response continued)

5. Was a RN/MD assessment of current patient mental status, patient behavior, reasons for S&R and other less restrictive alternatives, including less restrictive seclusion or restraint procedures, which were considered documented?

IV. Recommendation: WSH must clearly explain to patients both the reason(s) why they have been placed in seclusion and restraint and the criteria for release therefrom.

In the attached monitoring document, item # 8 addresses this recommendation:

8. Were human rights observed and the reason for seclusion and/or restraint explained to the patient as well as the criteria for release?

V. Recommendation: WSH staff must follow WSH's policy as written, including the documentation requirements. Hospital administration must enforce this requirement.

For all instances of emergency seclusion or restraint use, effective July 1, 2001, WSH will utilize the attached monitoring instrument to ensure that facility policies and appropriate documentation related to seclusion or restraint are followed by all staff. Problem areas or individuals will be identified via these reviews. Supervisory staff will utilize feedback, education and the disciplinary process as needed to ensure compliance.

DOCUMENTATION REVIEW FOR SECUSION, RESTRAINT AND SECLUSION ROOM/RESTRAINT CARE

Unit:

Patient Name: _____
Date of Intervention: _____
RN Assigned During Shift: _____
RN Completing Form: _____

Registration #_____
Review Completed By: _____
Date Review Completed:_____

1. Was behavior evidencing imminent likelihood of harm documented.	Yes	No
2. ** Were at least three less restrictive interventions documented.	Yes	No
3. Were dangerous behaviors indicating lack of response to lesser restrictive measures & continued behavioral emergency documented	Yes	No
4. Were MD orders for seclusion and/or restraint and behavioral criteria for release documented.	Yes	No
5. Was RN/MD assessment of patient current mental status, patient behavior, reason for S&R and other less restrictive alternatives, including less restrictive seclusion or restraint procedures, which were considered documented.	Yes	No
6. Were changes in patient behaviors during seclusion or restraints process which led to re-evaluation of intervention described.	Yes	No
7. When Mandt System of physical interventions was provided, were technique(s) documented.	Yes	No
8. Were human rights observed and reason for seclusion and/or restraint explained to patient, as well as criteria for release.	Yes	No
9. Following the use of physical intervention, did the nurse assess the patient for physical discomfort and document nursing observations	Yes	No
10. When RN evaluated a patient complaint, was there documentation for referral for MD follow-up.	Yes	No
11. Were patient behaviors and staff interventions documented every 15 minutes on ID Notes for Special Observations.	Yes	No
12. Was RN assessment of physiologic needs documented to include: a. nutrition b. skin condition c. hydration d. ability to ambulate e. level of alertness/activity f. restraint adjustment/range of motion g. circulation at least hourly	Yes	No
13. Were fluids offered every hour documented ** (Patient in SR/Restraints, less than one hour).	Yes	No
14. Were meals offered/served at regular meal times documented **(Patients not in SR/Restraints at mealtime).	Yes	No
15. Were vital signs and BP readings documented and if were not done, was the reason why noted.	Yes	No

DOCUMENTATION REVIEW FOR SECUSION, RESTRAINT AND SECLUSION ROOM/RESTRAINT CARE

Unit:

Patient Name: _____
Date of Intervention: _____
RN Assigned During Shift: _____
RN Completing Form: ___

Registration #_____
Review Completed By: _____
Date Review Completed: _____

16. Were patient strengths/resources and actions described and utilized to expedite release.	Yes	No
17. Did the RN document outcomes of physical evaluation after release (skin color, integrity, turgor, gait/balance)	Yes	No
18. Is there evidence that the patient is released when criteria for release are met.	Yes	No
19. Did the documentation indicate that the event was reviewed with the patient to include: a. patient perception b. helpful intervention c. interventions for future self management d. relevant information added to the CTP/NCP.	Yes	No
20. Were Seclusion and/or Restraint Forms completed in 24-hours to include: a. RN/Staff signature on ID Note for Special Observations b. Hourly RN Assessment c. ID Note for Release From Seclusion/Restraints	Yes	No

**** = Met with Exception - relates to the fluid and mealtime provision exceptions**